MONITORING , MOTIVATION, CONTINUING EDUCATION EVALUATION, RESEARCH AND TRAINING SYSTEM IN

ICDS

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FOREWORD

ICDS — after 17 years of existence and progressive expansion, has entered into a new and more exciting phase for mother and child care. There is great interest and increasing input for the new programmes supported by the international and bilateral agencies. It is a new type of challenge for administrators and professionals to make the best use of the resources of different programmes and focus them for maximum advantage to the children and mothers.

CTC is doing its best to develop the strategies which will be cost-effective. This monograph is the new edition of the earlier one popularly known as the 'Red-Book'. It should be very helpful to our front-line officers at the District and Block Headquarters for discharging their functions as Chief District, District, Project and Sector Advisers. The Child Development Project Officers will also find this monograph a very useful reference document.

I am very grateful to Lt. Gen. Y. Sachdev, AVSM who has been the principal person in compiling and editing this monograph. The chapters on training, research and evaluation and monitoring have been written by Dr. Umesh Kapil, Lt. Gen. Y. Sachdev, Mrs. Neeru Gandhi, Dr. K. L. Sikka, Mr. S. S. Rawat and Ms. Sarita Manocha respectively. Shri K. S. Krishnamurthy has played the most important role for coordinating all the technical presentation. The contents concerning administration and accounts have been provided by Shri M. C. Gupta, Shri A. K. Gupta and Shri Avinash Chander Bhateja.

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ABBREVIATIONS

AIIMS	—	All India Institute of Medical Sciences
ANM	—	Auxiliary Nurse-Midwife
AW	—	Anganwadi
AWC	—	Anganwadi Centre
AWW	—	Anganwadi Worker
BDO	—	Block Development Officer
CDPO	—	Child Development Project Officer
CDA	—	Chief District Adviser
CHC	—	Community Health Centre
CMO	—	Chief Medical Officer
CTC	—	Central Technical Committee
DA	—	District Adviser
DPT	—	Diphtheria, Pertussis, Tetanus
DFWPO	—	District Family Welfare Planning Officer
DHO	—	District Health Officer
DMOH	—	District Medical Officer Health
EPI	—	Expanded Programme of Immunisation
HA	—	Health Assistant
HQ	—	Headquarter
ICDS	—	Integrated Child Development Services
LHV	—	Lady Health Visitor
MMR	—	Monthly Monitoring Report
MO	—	Medical Officer
MPR	—	Monthly Progress Report
MPHW (F)	—	Multipurpose Health Worker (Female)
MS	—	Mukhya Sevika
NPMCD	—	National Programme for Mother and Child Development
ODA	—	Officer In-charge Data Analysis
ORS	—	Oral Rehydration Solution
PA	—	Project Adviser
PO	—	Programme Officer
PHC	—	Primary Health Centre
Sr. A.	—	Senior Adviser
SA	—	Sectoral Adviser
SC	—	State Coordinator
SHC	—	Subsidiary Health Centre
TT	—	Tetanus Toxoid

INTEGRATED CHILD DEVELOPMENT SERVICES

CHAPTER I

INTRODUCTION

Integrated Child Development Services (ICDS) Scheme was launched on 2nd October, 1975 in pursuance of the National Policy for Children in 33 experimental blocks. Success of the scheme led to the expansion of ICDS to 2696 projects by the end of March, 1992.

ICDS is a multi-sectoral programme and involves several Government departments and their services are coordinated at the village, block, district and State/Central Government levels. The primary responsibility for the implementation of the programme lies with the Department of Women & Child Development, Ministry of Human Resource Development at the centre and the nodal departments at the States which may be Social Welfare, Rural Development, Tribal Welfare or Health & Family Welfare Department.

The beneficiaries are children below 6 years, pregnant and lactating women and women in the age group of 15 to

44 years. The beneficiaries of ICDS are to a large extent identical with those under the Maternal and Child Health Programme.

The objectives of ICDS are : To

- Improve the nutritional and health status of children in the age group 0-6 years;
- Lay the foundation for proper psychological, physical and social development of the child;
- Reduce the incidence of mortality, morbidity, malnutrition and school drop-out;
- Achieve effective co-ordination of policy and implementation amongst the various departments to promote child development and;
- Enhance the capability of the mother to look after the normal health and nutrition needs through proper nutrition and health education.

Towards achieving these objectives, a package of services is rendered essentially through the Anganwadi Workers at the village centre called 'Anganwadi'. The supportive supervision is done regularly by the functionaries of the nodal and health departments. The nodal department functionaries have a primary responsibility for provision of supplementary nutrition and non-formal education to the beneficiaries of the programme.

The ICDS package of services includes :

- Supplementary nutrition, Vitamin 'A', Iron and Folic Acid.
- Immunisation.
- Health check-up.

- Referral services.
- Treatment of minor illnesses.
- Nutrition and health education to women.
- Pre-school education of children in the age group of 3-6 years.
- Convergence of other supportive services like water supply, sanitation etc.

ICDS Projects as on 31.3.1992

The statewise distribution of ICDS projects is shown in the following Table. The projects are located on priority in the tribal areas, rural areas with predominant Schedule Caste population and the urban slums.

Statewise position of ICDS as on 31.3.1992 :

S. No.	States/UTs	No. of projects sanctioned			Operational Projects
		State Sector	Central Sector	Total	
A.	**STATES**				
1.	Andhra Pradesh	9	160	169	148
2.	Arunachal Pradesh		38	38	36
3.	Assam		62	62	58
4.	Bihar		245	245	211
5.	Goa		11	11	11
6.	Gujarat	15	109	124	116
7.	Haryana	44	49	93	91
8.	Himachal Pradesh		34	34	32
9.	Jammu & Kashmir	23	42	65	63
10.	Karnataka	30	118	148	136

11.	Kerala	24	66	90	85
12.	Madhya Pradesh		231	231	209
13.	Maharashtra		175	175	155
14.	Manipur		25	25	23
15.	Meghalaya		28	28	26
16.	Mizoram	2	19	21	21
17.	Nagaland		26	26	25
18.	Orissa		176	176	134
19.	Punjab		62	62	60
20.	Rajasthan	17	119	136	126
21.	Sikkim		4	4	4
22.	Tamil Nadu		111	111	105
23.	Tripura		19	19	19
24.	Uttar Pradesh	8	353	361	313
25.	West Bengal	16	184	200	180
B.	**UNION TERRITORIES**				
26.	Andaman-Nicobar		4	4	4
27.	Chandigarh		2	2	2
28.	Dadra & Nagar Haveli		1	1	1
29.	Daman & Diu		2	2	2
30.	Delhi	2	25	27	26
31.	Lakshadeep		1	1	1
32.	Pondicherry		5	5	5
Total :		190	2506	2696	2428

ORGANISATION

The administrative unit for the location of an ICDS Project is a community development block in the rural areas, a tribal development block in the tribal areas, and a group of slums in urban areas.

An 'Anganwadi' is the focal point for the delivery of the services to children and mothers at their door steps. An Anganwadi normally covers a population of 1000 in both rural and urban areas and 700 in tribal areas. The number of anganwadis in any project can be increased according to local needs on the basis of population, topography, number of villages etc. Services at the Anganwadi are delivered by an Anganwadi Worker. The Anganwadi Worker, is a part-time honorary worker and receives an honorarium. She is assisted by a helper who is also a local woman and is paid a small honorarium.

The work of Anganwadi workers is supervised by full-time workers, the Mukhya Sevikas (MS). They are appointed at the proportion of one for 25,20 and 17 anganwadis in urban, rural and tribal projects respectively.

The infrastructure of the health services is an important component for implementation of ICDS. Medical Officer Incharge of the old PHC (New CHC) corresponds to CDPO and is over all incharge of the health components of ICDS. The health infrastructure, has at least 3-4 Medical Officers in each old PHC (Block) area with about 100 villages in rural set up. One Medical Officer is made incharge of one sector constituted by 20-25 villages (New PHC). One Health Assistant (HA) corresponding to the MS looks after ICDS work in 20-25 Anganwadi Centres. There are 4-5 Female multipurpose workers (MPW-F) under each HA in a sector. Each MPW-F is responsible to supervise the work of 5-6 AWCs.

ICDS being a multi-departmental and inter-sectoral programme, the coordination machinery has been set up at all levels of management. CDPO and MO under supervision of district authorities coordinate the ICDS implementation at the block level. The Deputy Commissioner or Collector is responsible for coordinating the implementation of the scheme at the district level. Districts having five or more ICDS projects, have ICDS monitoring cells. These cells include an ICDS Programme Officer, a statistical assistant, an office supervisor, an upper division clerk, a driver and a peon. Districts with 80 per cent coverage have a nutritionist, a pre-school instructor, a social work instructor, a health education instructor, an accountant, and a typist. At the State level, the Secretary of the Department of Social Welfare or any other nodal department designated by the state government, is responsible for the implementation of the programme. Special ICDS cells have been set up at the State headquarters to monitor the programme at the state level. At the centre level, the Department of Women and Child Development of the Ministry of Human Resource Development is the nodal department for the implementation of this programme.

Central Technical Committee of ICDS (CTC) :

The Central Technical Committee (CTC) on Health and Nutrition was constituted in 1976 to provide technical assistance to the Department of Women & Child Development. The CTC established a Central Cell with the following functions :

- Assist the State Health Department in monitoring the health and nutrition components and continuing education activities of ICDS;

- Organise and evaluate the flow of service and their impact through annual surveys and periodic research studies and

- Train the medical and health staff of ICDS projects.

CTC is headed by the Chairman and its members are Deputy Secretary/Director (CD), Department of Women & Child Development, Ministry of Human Resource Development; Deputy Adviser (PEO), Planning Commission; Jt. Secretary (Immunisation), Ministry of Health & Family Welfare; Director, National Institute of Public Cooperation & Child Development; Director, National Institute of Health & family Welfare; and President, Indian Academy of Paediatrics.

CTC is assisted at the Centre as well as at State level by Senior Consultants who are highly experienced persons dedicated to the National Health Programmes, particularly those targetted at Child Development.

CHAPTER II

MONITORING, MOTIVATION AND CONTINUING EDUCATION

Monitoring, Motivation and Continuing Education (MMC) at the periphery (Project level) are the most important activities of ICDS. Central Technical Committee (CTC) through state health infrastructure is responsible for MMC of the Health and Nutrition components while Women & Child Development (WCD) and Nodal ICDS department at the state is responsible for this activity for other components of ICDS. The subject of MMC will be discussed under following sections :

1. Functionaries of MMC
2. Monitoring System
3. Continuing Education
4. Motivation of Functionaries
5. Financial Assistance
6. Appendices (Formats for reporting).

1. Functionaries of MMC

The existing medical staff members of the Health and Family Welfare department have been designated as Honorary functionaries in ICDS for MMC activities. The full time and honorary staff of the nodal department for ICDS participate as team members for MMC system of CTC. The functions of health and nodal department staff members in reference to their designation in MMC system are as follows :

I. **State Co-ordinator** (SC) : Director-in-chief or Director Health Services or Director Family Welfare and MCH is designated as Honorary State Co-ordinator of ICDS. He has following functions : To

- Liaise with the state nodal department.
- Initiate actions for the appointment of Senior Adviser, Officer-in Charge Date Analysis Cell and Consultants.
- Take steps for the appointment of Chief District Advisers, Project Advisers and allotment of operational projects to them.
- Facilitate the ICDS projects with the maximum possible inputs of health functionaries.
- Divide the ICDS projects amongst the Consultants for specified functions.
- Ensure adequate supply of medicines, vaccines, equipment etc. in ICDS project areas.
- Facilitate Consultants' work in training, survey, and research.
- Organise state quarterly meetings and divisional meetings.

- Ensure the regular and timely submission of reports by the functionaries of the state.
- Take necessary steps to improve the quality of monitoring on the basis of the monthly feedback received from the Central Cell.
- To take part in training course for social welfare functionaries.
- Submit the following reports to the Central Cell, on the prescribed proforma :
  - Quarterly progress report within 45 days after the end of each quarter;
  - Quarterly expenditure statement within 15 days after the end of each quarter.

II. **Senior Adviser (SA) :** A senior official of the Health and Family Welfare department is appointed as Senior Adviser. He has following functions : To

- Ensure that ICDS projects of the State/UT are being monitored regularly.
- Participate in district level monthly meetings by rotation so that each district's ICDS performance is reviewed on-the-spot, at least once a year or more. A short report should be forwarded to the Central Cell after each visit.
- Review and ensure the quality of the continuing education at the sectoral level.
- Visit at least one ICDS project each month and submit the report to the Central Cell and State Coordinator.

- Liaise with the State Co-ordinator on various problems of individual projects on the basis of observations made during his field visits, reports received by State Co-ordinator and monthly feed-back received from the Central Cell.

- Attend district level seminars being organised by the Social Welfare functionaries. (TA and DA will be paid by the nodal department).

- Take part in training course for Social Welfare Functionaries. (TA and DA will be paid by the sponsors).

- Submit the following reports to the Central Cell, on the prescribed proforma :

  - Quarterly progress report within 30 days after the end of each quarter.

  - Quarterly expenditure statement within 15 days after the end of each quarter.

III. **Officer-in-Charge Data Analysis Cell (ODA) :** An appropriate staff of the Health & Family Welfare department may be appointed to this post on the recommendation of the State Co-ordinator. The ODA has following functions : To

- Ensure completion and submission of State Co-ordinator's quarterly report to Central Cell within specified period.

- Help the State Co-ordinator in organising state level meetings and divisional meetings.

- Help the State Co-ordinator in initiating necessary ac-

tions for improvement in functioning of ICDS projects on the basis of monthly feedback received from the Central Cell.

- Monitor the establishment and functional status of ICDS projects sanctioned.
- Ensure the regular receipt of monthly monitoring returns from the Project Advisers, and Chief District/ District Advisers to formulate appropriate actions for the supply of drugs, vaccines and supplementary nutrition.
- Prepare monthly summary report on the basis of the MMRs from the various functionaries and the feedback from the Central Cell.
- Ensure the submission of expenditure statements to the Central Cell at the end of each quarter as specified.
- Take part in training courses for social welfare functionaries. (TA/DA to be claimed from the organiser).

IV. Chief District Adviser (CDA) : The Head of the Medical & Health department at the district headquarter is designated as Chief District Adviser. His functions are as follows : To

- Distribute ICDS projects amongst the District Advisers as per guidelines from the Central Cell.
- Depute the District Advisers as per guidelines from the central cell.
- Organise district level monthly meetings with District Advisers, Project Advisers, CDPOs and Programme

Officer to review the progress and to resolve the difficulties for effective implementation of the programme and use feed back data received from CTC for this purpose.

- Take a lecture at the district level meeting on one health subject as a part of continuing education.
- Report to the Central Cell by 21st of each month about monthly progress review on the prescribed proforma (Format 5).
- Participate in the State Quarterly and Periodic Divisional meetings and report the progress of ICDS projects in his district.
- Ensure that the ICDS Project/PHC area is divided amongst the Project and Sectoral Advisers for continuing education and monitoring.

V. District Adviser (DA) :

Second level Medical and Health Official of the district such as Deputy CMO, Additional CMO, DHO, DFPO, District TB, Malaria and Leprosy Officer and Immunisation Officer etc. is designated as District Adviser for the ICDS projects. Generally, one to three ICDS projects are allocated to him. DA has following functions : To

- Organise monthly PHC/Project level meeting of MOs, CDPOs, MSs and LHVs for :
  - Continuing education as per guidelines, and
  - Review of the monthly monitoring report of Project Advisers and ensure its timely despatch to the CDA, Central Cell and State Co-ordinator.

- Take a lecture at PHC/Project meeting on one of the listed subjects as part of continuing education.
- Submit his Monthly Monitoring Report to the Central Cell and State Coordinator within 11 days after the end of each month on the prescribed proforma (Format 4).
- Distribute the ICDS project/PHC area amongst the Project and Sectoral Advisers for continuing education and monitoring, with the concurrence of Chief District adviser.
- Participate in the :
  - District level meeting organised by Chief District Adviser.
  - State quarterly meetings when desired by State Co-ordinator.
  - District level seminar conducted by Social Welfare department.
  - Deliver lectures for Social Welfare functionaries.

VI. Project Adviser (PA) :

Seniormost Medical Officer of the Primary Health Centre/new Community Health Centre (MO I/C-PHC/ CHC) is designated as Project Adviser. PA has following functions :- To

- Divide the ICDS project /PHC/CHC area for monitoring and continuing education into 4 or 5 Sectors or new PHCs depending upon the number of MSs and allot them to Medical Officers (Sectoral Advisers) with approval of Chief District Adviser/District Adviser. He must keep one sector under his direct charge.

- Prepare Monthly Monitoring Report (MMR) of the PHC/CHC on the prescribed proforma with the help of a clerk/computer on the basis of the data obtained from the AWW's MMR (checked by MPW (F)/LHV and Sectoral Adviser).

- Present his MMR of the last month at the monthly PHC level meeting to the District Adviser and despatch the same to the Central Cell and the State Co-ordinator within eight days after the end of each month.

- Attend monthly district level meeting of Chief District Adviser and report progress of ICDS project.

VII. Sectoral Adviser (SA) :

Each ICDS Project/PHC/CHC is divided into sectors corresponding to the area of one MS. One Medical Officer is made incharge of one sector, and is designated as Sectoral Adviser. This Medical Officer is selected from PHC or SHC or even a dispensary in the PHC area. SA has following functions :- To

- Arrange a monthly meeting during the last week of each month with all AWWs, MPHWF, LHV and MS of the sector at one village of the sector designated as Sectoral Head Quarter.

- Review the progress and initiate actions for improvement of the ICDS services in the sector.

- Take a class for continuing education at the monthly meeting on one of the subjects listed in continuing education.

- Prepare a sectoral report on the prescribed proforma and

submit it along with the AWW's MMRs to the Project Adviser (MO I/C PHC/CHC) on the 1st working day of the following month.

B : Staff of the ICDS Nodal Department :

The Child Development Project Officer (CDPO) and Mukhya Sevika (MS) who are the full-time workers of ICDS and Anganwadi Workers (AWWs) who are the honorary functionaries, are the team members of MMC system. Their functions, as stated in the guide-book by the Women & Child Development, are as under :

I : Child Development Project Officer (CDPO) :- To

- Supervise, coordinate and guide the work of the entire ICDS project as it's incharge at the block level.
- Collect information and, in the initial stages, guide the anganwadi workers in carrying out a quick sample survey of the project villages to enumerate and identify children, pregnant women and nursing mothers for preparing a project report containing all necessary and relevant baseline information.
- Act as the Convenor or Secretary of the Block Level Coordination Committee.
- Maintain functional liaison with the block headquarter, PHC, Panchayat, Voluntary Organisations, Mahila Mandals, Youth Clubs and Primary Schools functioning in the project area.
- Make efforts for obtaining local community's involvement and participation by making it contribute in terms of food supplies, building materials, voluntary service etc. in implementing ICDS and Functional Literacy Schemes.

- Arrange educational programmes like nutrition and hygiene demonstrations with the help and assistance of the personnel under his/her charge and other block personnel.
- Take all necessary measures for ensuring staff recruitment and training.
- Finalise monthly and yearly budgets and incur necessary expenditure relating to ICDS and functional literacy schemes.
- Act as the Drawing and Disbursing Officer for the ICDS and Functional Literacy Schemes excluding the health inputs.
- Make necessary arrangements for obtaining, transporting, storing and distribution of various related supplies by maintaining necessary links with district and state officials.
- Ensure that all the equipment and material supplied for the ICDS programme are accounted for and are used and maintained properly.
- Ensure the maintenance of proper registers and records, both at the block and anganwadi level and inspect these records periodically.
- Ensure despatch of periodical progress reports and all information to higher officials, state and central ICDS units, as and when required.
- Undertake field visits and call staff meetings periodically and to submit to higher officers the tour programme chalked out in consultation with the BDO and

PHC doctor The tour will be for at least 18 days a month with ten night halts outside the headquarters.

- Enlist cooperation of all the officials and concerned non-official agencies in the project area.
- Check the diaries maintained by the Mukhya-Sevikas (for each financial year) both through random checks and periodical inspections and ensure that instructions in this regard are followed scrupulously.

II. Assistant CDPO : To

- Assist the CDPO in discharging his/her duties in such a manner as may be indicated by the CDPO.
- Attend to the items of work mentioned at S. No. (ii), (iv), (v), (vi), (x) and (xiv) in the list of job responsibilities of the CDPO mentioned above.
- Attend to office work when the CDPO is on tour as per the arrangements that may be indicated by the CDPO.

III. Supervisor (Mukhya Sevika) :-

- A supervisor will provide continuous on-the-job guidance to anganwadi workers to bridge the gap between training and job requirements.
- She will visit each anganwadi at least once a month, liaise with LHV for a joint visit to one anganwadi once a week, and make at least one night halt every week in a village located at a distance of more than 5 Kms from her Circle Headquarters.
- During her visit to anganwadi, she will perform the following tasks :

- Guide anganwadi workers in conducting household surveys, updating the survey data on a quarterly basis and preparing accurate lists of families and eligible beneficiaries.
- Check the enlisting of beneficiaries from low economic strata and severely malnourised, particularly children below 3 years of age.
- Guide anganwadi workers in the assessment of correct ages of children, correct weighing of children and plotting their weights on the growth chart, especially in respect of severely malnourished.
- Help the anganwadi workers in identifying "at risk" children and mothers and referring them to primary health centre or hospital.
- Check the weights, by actual weighment, of severely malnourished children and guide the anganwadi workers in their rehabilitation.
- Guide the anganwadi workers in conducting pre-school activities by demonstrating techniques of story telling, organising play, identification of shades and colours etc.
- Demonstrate to anganwadi workers the effective methods of providing health and nutrition education to mothers and help them to do the same.
- Guide anganwadi workers in prevention and early detection of early childhood disabilities.
- Visit homes of severly malnourished children and "at risk" mothers and guide anganwadi workers and mothers about proper care in such cases.

- Check the entries of deaths and births in the survey register and the immunisation register.
- Check the records of anganwadi workers and guide them in proper maintenance of records.
- Organise help in cases of those anganwadi workers who are not educated enough to fill in the registers and maintain records.
- Check the arrangement for storage, preparation and distribution of food and stocks of supplies, such as supplementary nutrition, medicines, material for pre-school education, registers, records etc. and report shortages to the CDPO.
- Help anganwadi workers in organising and strengthening Mahila Mandals which could support various activities of the anganwadis.
- Keep in touch with village leaders and local institutions such as Mahila Mandals, Panchayats, Primary Schools and youth clubs and involve them in ICDS programme.
- Find out the personal and work-related problems of anganwadi workers, provide guidance to them to cope with these problems and report gaps to CDPO.
- Ascertain the number of visits by ANM to the anganwadi during the period between the supervisor's previous visit and the current visit, and whether the ANM's visit was properly utilised by collecting children and mothers who were too sick to come to the anganwadi.

- Check whether the weekly time table of activities at the anganwadi is being properly implemented and
- Ascertain the number of unimmunised children and report it to the CDPO.

- The supervisor shall organise monthly meeting of anganwadi workers of her circle with the participation of concerned LHV/LHVs and ANMs. At this meeting, the work for the ensuing month should be planned, including preparation of weekly time-tables of activities at the anganwadi. One or two specific items should be selected for continuing education to anganwadi workers and ANMs at each monthly meeting (for example, growth monitoring, diarrhoea management, coping with any rampant disease etc.)

- The supervisor shall maintain a diary in the prescribed form in which she will keep a record of the work done by her during her visit to the anganwadis and maintain the statistics relating to population, number of pregnant and nursing mothers, number of beneficiaries of different services, number of severely malnourished children etc. of the anganwadis in her area.

- The supervisor will ensure timely submission of monthly progress reports by anganwadi workers to the CDPO and also check the accuracy of these reports.

- At the monthly meeting at project headquarters, the supervisor will assist the CDPO in the following matters :
  - Payment of honoraria to anganwadi workers and helpers in her circle.

- Alternative arrangements in case of anganwadi workers and helpers, who may go on leave in her circle.
- Finalisation of the mutually convenient date for the monthly meeting in her circle in the following month.
- Informing the meeting about any special event or problem or achievement in her circle; and
- Issue of materials from the project office to the anganwadi workers.

- She will carry out such other tasks as may be entrusted to her by the CDPO.

IV. **Anganwadi Worker :** To

- Weigh each child every month, record the weight in graph on the growth card, use referral card for referring cases of mothers/children to the sub-centres/PHC etc. and maintain child cards for children below 6 years and produce these cards before the visiting medical and para-medical personnel.
- Carry out a quick sample census of all the families especially mothers and children in those families in their respective area of work.
- Organise non-formal activities in an anganwadi for about 40 children in the age group 3-6 years of age and to help in designing and making of toys and play equipment of rural character and origin for use in anganwadi.

- Organise supplementary nutrition feeding for children (0-6 years) and expectant and nursing mothers by planning the menu based on locally available food and local recipes.
- Provide health and nutrition education to mothers.
- Make home visits for educating parents to enable mothers to plan an effective role in the child's development particularly in the case of children attending the anganwadis.
- Elicit community support and participation in running the programme.
- Assist the PHC staff in the implementation of health component of the programme viz. immunisation, health check-up etc.
- Maintain routine files and records.
- Bring to the notice of the CDPO any development in the village which requires further attention, particularly in regard to the work of the coordinating arrangements of different departments in the villages.
- Maintain liasion with other institutions (Mahila-Mandals) and involve lady school teachers and girls of the primary/middle schools in the village which have relevance to their functions.

V. Helper to AWW: To

- Cook and serve the food to children and mothers.
- Clean the anganwadi premises daily and fetching water.
- Ensure cleanliness of small children.
- Bring small children from the villages to the anganwadi.

2. Monitoring System

Monitoring has been the integral part of ICDS since its inception. In view of the rapid expansion of the scheme, the system of monitoring has been periodically modified and the strategy has changed in four phases. Each new phase increased the number of health functionaries placed at different levels for monitoring the health components of ICDS.

First Phase (October 1975 to October 1978) : Monitoring was carried out by Consultants in the departments of Pediatrics and Community Medicine at medical colleges in 33 pilot projects. The Consultants were responsible for Survey, Monitoring and Training.

Second Phase (November 1978 to June 1981) : The number of projects increased from 50 to 150. Senior officers of the state Public Health Department and District Pediatricians were also involved as consultants for monitoring of projects.

Third Phase (July 1981 to March 1985) : Medical Officers incharge Primary Health Centre at project level, District Health or District Medical Officers (District Advisers) at district level and senior officers at state level (State Coordinators, Senior Advisers and Officers Incharge Data Analysis Cell) were entrusted the responsibility of monitoring. In this phase Monthly Monitoring Reports (MMRs) from Anganwadi Workers (AWWs) were compiled by MO Incharge PHC and submitted to Advisers, after scrutiny and comments. The Advisers then prepared a consolidated report in the prescribed format at district level and submitted the same directly to Central Cell with a copy to the State Coordinator.

In 1982, Medical Officers of the PHCs and District Advisers were given additional responsibility of continuing

education at project, sector and peripheral level. After Annual Convention 1983, the advisers and MOs were given a format to make a report at the end of each quarter for continuing education carried out by them at project/sector level and by MOs of primary health centres at sector level. Place, date and subject of continuing education alongwith the nature and number of participants were reported. In 1983, after 2 years of the 3rd phase, the report of the medical officer incharge included information on staff, supply position of drugs, vaccines, Anganwadis visited, sectoral training and immunisation activities and vital statistics.

Current System of monitoring (Since 1985) :

Presently there are two channels of monitoring systems in ICDS. One entitled "Monthly Progress Report" (MPR) relates primarily to the Social Welfare Components and the other "Monthly Monitoring Report" (MMR) concerns with health and nutrition components. The reports flow through two different channels and are compiled by the Department of Women & Child Development and the Central Technical Committee at New Delhi respectively. The current system of reporting by MO incharge PHC was adopted in March 1985. It is known as "Monitoring, Motivation and Continuing Education System".

Monitoring Unit in Rural and Tribal Projects :

The unit of monitoring of health and nutrition components of ICDS is PHC (New CHC). The PHC area is divided into 4 sectors corresponding to functional zone of 20-25 villages for each MS of ICDS. One MO is in charge of a sector for monitoring the work of 20-25 Anganwadis and providing motivation and continued education to the functionaries of the sector.

Periphery to Apex Flow of Monitoring Reports : (Fig. 1)

The flow of monitoring from the village Anganwadi to state is as following :

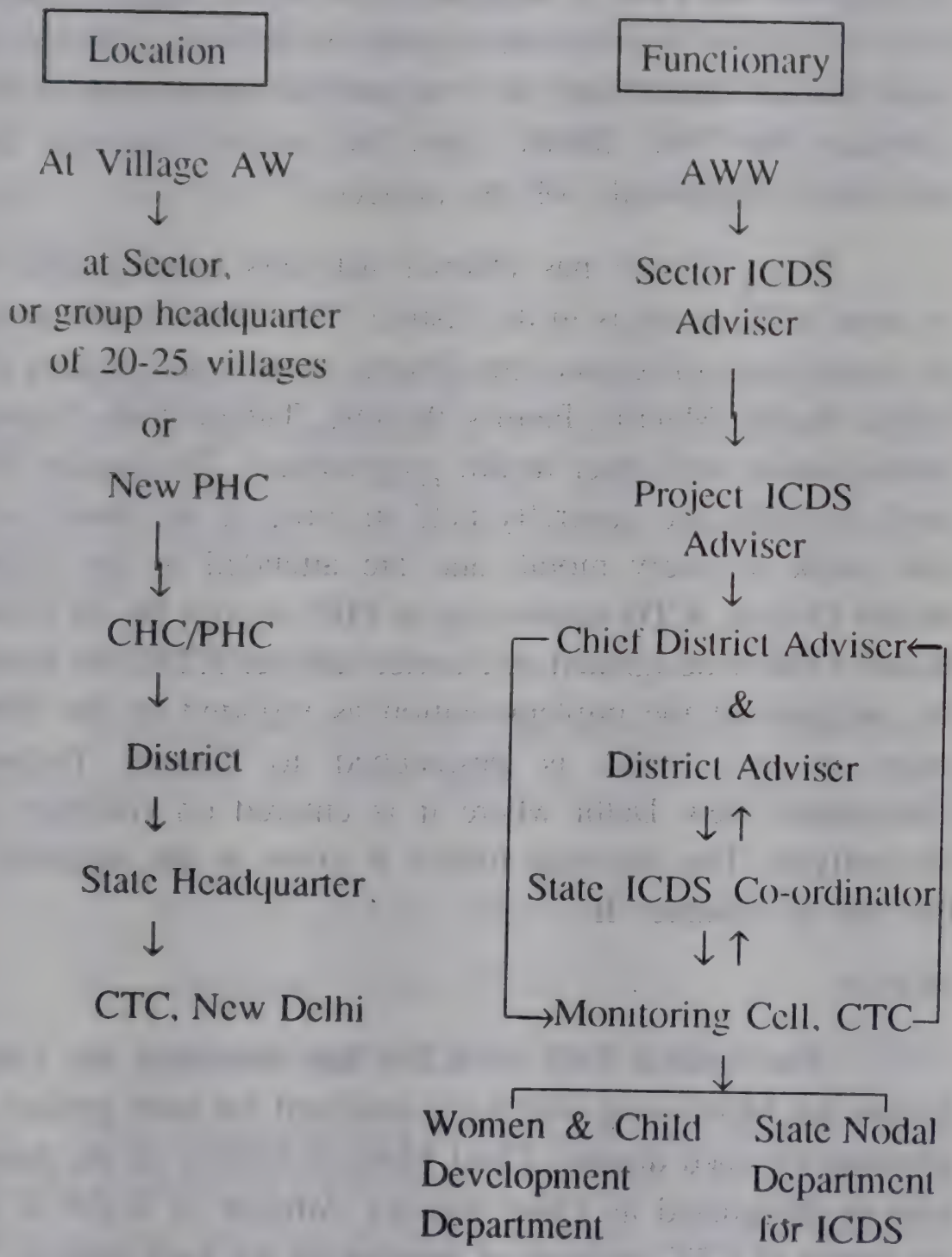
Anganwadi Centre :

The Monitoring of Anganwadi Centre is done by review of the Anganwadi Worker's monthly Monitoring Report (Format1). The report (MMR) is prepared by AWW for each month. The MMR so prepared is scrutinised by the ANM/LHV responsible for the Anganwadi.

Sector :

Each sector generally comprises of 20 to 25 AW centres in a rural ICDS project and 15 to 17 AW centres in a tribal ICDS project. Each sector corresponds to the areas of one Supervisor (Mukhya Sevika). The health functionaries of the PHC, subcentres and rural dispensaries have been allocated respective sector for their health duties. The sectoral headquarter may be a subcentre, rural dispensary or even the PHC depending on the area of the sector. One of the Medical Officers from the PHC area(regardless of his funding or place of work, PHC/subcentre/dispensary) is designated as Sector Adviser and he is responsible for the monitoring, motivation and continuing education of the functionaries of the sector under his charges. Sector Adviser (MO) organises a sectoral meeting between 26th to 30th of every month which is to be attended by all AWWs, ANMs, LHV and MS (supervisor) working in the sector. New PHC may act as nodal point for sectoral conferences.

Flow of Monthly Monitoring Reports
(Health & Nutrition)



(Figure-1)

Primary Health Centre (New Community Health Centre) :

The senior-most medical officer of the PHC or MO incharge of the PHC is designated as ICDS Project Adviser. Project Adviser receives the reports of Sectoral Adviser, and under his/her supervision, the computer/statistical clerk of PHC compiles the PHC MMR from the reports received from individual Anganwadis of the project.

Every district has District Advisers looking after one or more ICDS projects in the district. The District Advisers are the senior-most officials of the District health team looking after Public Health, Malaria, Family Welfare, Tuberculosis, Leprosy, Immunisation and other health programmes. The regular PHC level meetings are generally held in most of the states in the first week of every month and are attended by the District Health Officer. ICDS monitoring at PHC is done by the District Health Officer designated as District Adviser ICDS. He reviews the progress of the implementation as reported on the MMR. After review, MMR is despatched to Central Technical Committee, New Delhi where it is entered on computer file for analysis. The reporting format is given in the Appendix at the end of Chapter II.

District

The Central Cell of ICDS has identified the critical factors for Monitoring which are analysed for each project and grouped for each district. Chief Medical Officer of the district, who is designated as Chief District Adviser of ICDS is sent the report of CTC analysis of monitoring for each project. The Chief District Adviser reviews his report with the District Advisers, Project Advisers, CDPOs and Programme Officer at the regular monthly meeting. CDA sends the report of this

monthly meeting to the CTC. The reporting format is given in the Appendix.

Division

In several states, Divisional level conferences are conducted once in a year in which all district officials namely, CDAs, DAs, PAs, CDPOs and Programme Officers of all ICDS projects are invited for review of the implementation of ICDS and other MCH programmes. Senior Consultants, Senior Advisers and State Co-ordinators have a leading role in these conferences.

State Headquarter

Monitoring, Motivation and Continuing Education at state level is the responsibility of State Coordinator, Senior Adviser and Officer-in-charge Date Analysis. A formal programme of quarterly review of progress for each state is established.

Urban ICDS Projects

Monitoring, Motivation and Continuing Education is the responsibility of three types of functionaries in urban projects :

a) Medical College Consultants

b) Municipal Health Officers and

c) District Medical and Health Officers or CMOs.

The monitoring system has been developed and implemented according to local needs of the State. The varying health infrastructure facilities available in urban projects have been kept in view while developing the system.

Medical college Consultants : When the urban projects are situated close to the Medical Colleges:

The consultants are identified from the faculty of different departments in medical colleges. The functions of consultant would be like those of district adviser as outlined earlier and he will be responsible for one or more ICDS projects depending upon the number of projects functioning in the urban area. The medical college consultant may delegate the function to the other faculty members of the department.

In general, in each project, the medical officer would act as the Project Adviser. His functions are :-

- He will divide the project into sectors (usually four) equal to the number of MSs. Sector headquarter may be a MCH centre/ dispensary or other suitable place.
- He would regularly visit all the anganwadis of the project by rotation, 10-12 each month. He will conduct sectoral level meetings for monitoring and continuing education in all the 4 sectors from 26th to the last date of the month. The meeting will be attended by all the anganwadi workers of the sector, MS and ANM/ LHV.
- He will collect the AWWs' reports, scrutinise and suggest measures for improvements of ICDS activities.
- He will take a session of 30 minutes for continuing education on one of the listed subjects.
- He will prepare MMR of the urban project with the help of LHV or some other assistant from the basic data given in all the AWWs' MMRs. He will send Project Adviser's report to the Central Cell by 8th of the following month and one copy to the State Coordinator.

He will present his report for review at the project level meeting conducted by the consultant or his delegate each month.

The consultant would organise a monthly monitoring review meeting with the project adviser, ANMs, LHVs, AWWs and other staff during the first week of the month and review the progress of ICDS activities. The consultant would also take a lecture for continuing education during the meeting. A minimum of three hours would be spent during the project review meeting.

Consultant would make at least two field visits to each of the projects allotted to him every month and review the implementation of ICDS activities at the Anganwadi level.

In addition to above duties, Consultant would also be responsible for training, survey and research activities given to him from time to time.

Municipal Health Officer or his Deputies in the Corporations and large municipalities :

The Central Cell, with the help of local authorities would identify an urban Consultant/Urban Adviser for ICDS projects from amongst the Municipal Health Officer and his Deputies. He would supervise and monitor the urban ICDS projects as done by Medical College Consultant. He would conduct monthly project meeting and ensure that the MMR of the Urban project is despatched to Central Cell by the Project Adviser (MO, ICDS Project), before 8th of the following month.

Chief Medical Officer of the district (CDA) or his deputies (DAs) in urban areas having small municipalities.

Usually, the adequate infrastructure is not available in these areas. CDA will himself or his DA would supervise and conduct the monthly project meeting. He will have similar functions as in rural ICDS projects. The MO appointed from ICDS grant will function as Project adviser and discharge the duties as outlined for urban projects.

Monitoring system of urban projects in Delhi and Tamil Nadu has been designed in consultation with the health authority of the Union territory and the State respectively.

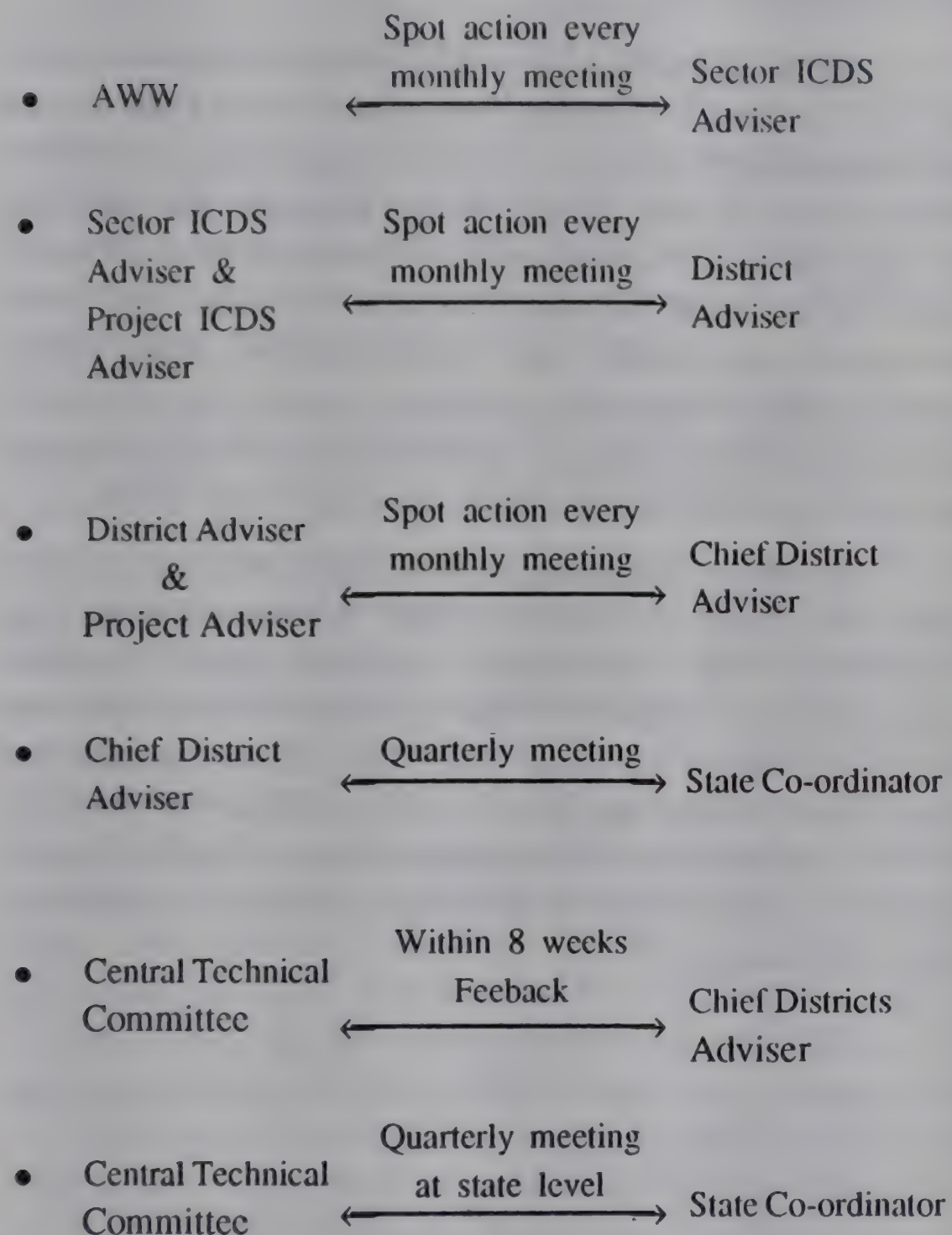
Actions on Monitoring Reports (Fig. 2)

Action on monitoring reports, within 5 days of closing of the month, is taken by the Medical Officer, who is incharge of a sector (20-25 Anganwadis) by providing solution to the problem presented by anganwadi workers and suggesting remedial measures for health and nutrition problems noted by him in the preceding month's report.

Action on monitoring reports, within 10 days of the closing of the month, is generated at the Primary Health Centre by the District Adviser and Project Adviser of the ICDS at the monthly meeting of the PHC in which Sector Advisers and CDPOs, Health Assistants and MS participate. Progress is reviewed with the help of Sector and Project Adviser's monthly reports. The District Level Officer suggests remedial measures to the problems noted in the preceding month reports.

Action on monitoring reports, within 20 days of the closing month, is taken by Chief District Adviser who takes the monthly review meeting with the Distict Advisers, Project Advisers and CDPOs and Programme Officers of ICDS. He reviews the progress of the scheme on the basis of consolidated reports of each project presented by the Project Adviser.

Feedback & Action through Monitoring System (Health & Nutrition)



(Figure-2)

Specific problems are identified and necessary actions are taken to ensure successful implementation of ICDS in all the Projects of the district.

Action on monitoring reports, within 45 days is undertaken, by the Central Technical Committee, at New Delhi, which consolidates project advisers' monthly reports received from the entire country for each project, district and state. The tabulated data obtained is further analysed and information on essential health and nutrition parameters is sent to CDAs for further intervention to improve the implementation. Consolidated monthly reports alongwith a summary of important parameters is sent to the Department of Women and Child Development and to State Coordinator, ICDS for review and action.

Action on monitoring reports, within 90 days, is taken at the State quarterly Meetings which are organised by State Coordinator. The Chief District Advisers, District Advisers, representatives of Social Welfare Department of the State and Central Cell attend the same. The ICDS scheme progress and achievements within the previous three months are reviewed with the help of Monthly Monitoring Reports (MMR). Specific problems are identified and remedial measures are undertaken during the meeting.

3. Continuing Education for Functionaries of ICDS Projects:

Continuing education of various levels of functionaries is one of the important on-going activities of Integrated Child Development Service Scheme. The continuous advance made in the field of health and nutrition call for regular monthly continuing education programme. This will help in greater understanding of newer problems and will fill the gap in the knowledge and thus, improve the quality of services. All along an integrated training approach of national programmes for mothers and child development is pursued.

There are three levels of continuing education in each ICDS project. The district level of continuing education is undertaken by the Chief District Adviser. At the PHC level continuing education of various levels of functionaries is being done along with the monthly review meetings by the District Adviser. The continuing education, at peripheral level, is provided by regular interaction and frequent exchange of information between the Anganwadi Worker and the Auxiliary Nurse Midwife, when they meet each other for various health programmes, such as, immunisation, health check-ups, distribution of iron & folic acid and vitamin A supplements, home visits, health and nutrition education, monthly monitoring report preparation etc. The ANM and AWW would look critically at the health and nutrition status of their areas and initiate ways and means of improving them. This also provides an opportunity for helping each other and for clarifying problems which need to be brought to the notice of the Medical Officer at the sectoral level or new PHC for further clarification. Although, there are no specific guidelines regarding the number of contacts between an ANM and AWW in a month, it is desirable to have regular informal contacts at least 4 times a month (once in a week).

At the sectoral level continuing education is done by Sectoral Medical Officer.

Topics for Continuing Education

Sectoral Level :

1. Objectives and goals of ICDS
2. Organisation and administrative set up in ICDS Project.
3. Enlistment of beneficiaries
4. Health check-up
5. Health and Nutrition Components of ICDS
6. Health staff in ICDS project and their co-ordinations
7. Ante-natal check-up and care of pregnant women
8. High-risk approach
9. Intra-natal care and child birth
10. Breast-feeding—the advantages
11. Monitoring of the child's nutritional status using weight, mid-upper arm circumference and growth charts
12. Immunisation schedule for children and pregnant women.
13. Acute respiratory infections and measures to control them at PHC level.
14. Diarrhoea and Oral Rehydration Therapy
15. Medicine kits with Anganwadi Workers and treatment of minor ailments
16. Weaning foods

17. Nutritional deficiencies-Anaemia, vitamin A deficiency, Goitre, Protein Energy Malnutrition

18. Nutrition and Health Education

19. Supplementry Nutrition for children, pregnant women and lactating mothers

20. Therapeutic Nutrition for severely malnourished children.

21. Early detection and prevention of childhood disabilities

22. Drinking water and environmental sanitation

23. Assessment of the health and nutrition status through monitoring reports

24. Infant and Toddler mortality

25. Home visits and their importance

PHC Level :

In Addition to above topics, the following are suggested topics for the District Adviser:—

1. Method of Reviewing and Monitoring at Sectoral level
2. Growth and development of children
3. Immunisation schedule—importance of cold chain, proper enlistment of beneficiaries and immunisation activities reporting under U.I.P.
4. Health check-up, referral system for AW centre onwards.
5. Inter-sectoral coordination between departments/agencies.
6. Community involvement in ICDS

7. Continuing Education, its need and Importance
8. Field visits and their importance
9. Mother-craft
10. Health programmes implemented through PHC
11. Supportive supervision of AWW by health workers

District Level :

In addition to the topics suggested for sectoral and PHC level meeting for continuing education, the following are other topics with emphasis on the administration and management which may be included at the district level:

1. Co-ordination with social welfare or nodal department functionaries
2. Orientation and training courses for Medical Officers, their need and importance
3. Mechanics of release of supplies, grants, vaccines etc.
4. Inter-sectoral and inter-departmental co-ordination of ICDS with MCH, UIP and family welfare departments and other agencies
5. Assistance to Consultants for survey and evaluation studies
6. Discussions on data from evaluation/research studies
7. Review of monthly monitoring reports specially feed-back from Central Technical Committee.
8. Discussion on decisions and proceedings of the state quarterly/and divisional meetings
9. Any specific health and nutrition problems.

Brief guidelines for the different topics of continuing education are as follows:—

A. SERVICE TO CHILDREN

1. Health check-up

The beneficiaries are children in age group 0 to below 6 years. Health check-up should be carried out by the Medical officer, LHVs and ANMs with the help of Anganwadi Worker.

Children should be examined at least once in every 1-3 months. The objective is to detect diseases, evidence of malnutrition, infection, 'at risk' cases etc.

- 'At risk' children
- Identification

'At risk' children are those who fall under one or more of the following categories:

- Weight below 50% of the reference standard.
- Difficulties in breast feeding and introduction of bottle feeding below six months of life, or delay in giving supplementary weaning foods.
- Failure to gain weight in three successive months.
- Birth weight of less than 2.5 kg.
- Twin births.
- History of death of two or more siblings below the age of 12 months.
- Death of either or both parents.

- Severe actute infection like measles or whooping cough.
- Birth order 4 or more.
- Spacing of children is less than 2 years.
- Only child after a long married life.
- Upper mid-arm circumference less than 13.5 cms (for age group 1-4 +).

•• Management of 'At risk' children

- Enlist them in a special care register.
- Make their weight charts carefully and take weight every month.
- Show these children to ANM/LHV/doctor at earliest and take their help for the treatment.
- Make home visits regularly to their families for necessary instructions.
- Give "therapeutic" nutrition and provide special care.
- Emphasise to the mothers that the child needs extra-food.

2. Assessment of age

First ask for any documentary evidence such as records of ANW, ANM, maternity home, horoscope or birth certificate of the child. If it is not available, proceed to obtain the following information for assessment of age:

Year: Events, such as floods, famine, election, new road, electricity connection etc.

Events in the family, such as death, birth, marriage and other ceremonies in the past.

Month: Seasons for planting, harvest, festivals, Desi months in the year under reference.

Date: Phase of moon.

The above mentioned method should be able to provide estimation of the age, with ± one month approximation.

3. Weighing of Children

Ideally, every child, under five years of age, should be weighed once a month. All children, under the age of 3 should be weighed every month. Children over the age of 3 with an upper mid-arm circumference under 13.5 cms (in the red or yellow zone of the tricoloured strip used to measure the upper mid-arm circumference) should also be weighed every month. The weight should be recorded on the growth chart each time the child is weighed.

- Method of Weighing

- Salter Weighing Machine

  - The scale should be suspended freely from a hook and should not rest against a wall.
  - The scale should be at eye level so that the weight can be read accurately and easily.
  - Adjust the scale to 'zero' before each weight is taken.
  - Take the measurement with minimum of clothing and without shoes.
  - Read the weight from a distance of one foot with eyes vertically at level of the dial.
  - Take the reading to the nearest marking. In case, the weight coincides with a division on the dial, read the

exact weight, but, in case, the weight is between the two divisions, then note and record in fractions of 100 g approximately.

- Always take two readings. If the two readings do not agree, take the average of the two.

- Record the weight clearly in the appropriate columns in the register/card.

- Check the accuracy of the weighing scale every week with standard weights.

Some of the new projects are being supplied now with, bar balance. Follow appropriate instructions for use of the same.

The most important fact about a healthy child is that he/she should gain weight at every weighment done at a monthly interval and his growth curve should be above the first line of the growth chart.

The weight for age graph (growth chart) has weights marked on the vertical line and age in 'months' on the horizontal line.

The growth chart in ICDS has four curves to indicate nutritional status of the child.

•• Plotting on Growth Chart

- It is essential to get the correct age of the child in 'months' before the child is weighed and his/her weight plotted in the chart. The age/date of birth should be written in block letters in the space provided in the chart.

- The child is weighed and the dot is put on the graph

opposite the place for his age in months and weight.

- If the child is weighed early in the month, the dot is put close to the left edge of the square, and if the weight is taken late in the month, the dot is put close to the right edge. The dot is put half way of the square, if the child is weighed in the middle of the month.

- If the child weighs an exact number of kilograms, the dot is put on the line for the whole kilogram. If a child's weight is above a whole kilo, the dot is put just above the whole kilo line, and if it is just below a whole kilo, it is put just below kilo line.

- The dots put after weighment are joined by a line which should climb up as the child grows older and heavier. The line of dots that a child's weight makes on the card is called his/her growth curve.

• Mid Upper Arm Circumference

In situations where facilities for weighing a child are not available, measurement of arm circumference with the help of a tricolour tape-each colour representing a fixed range of measurement to classify the child as normal, mildly malnourished and moderate to severely malnourished could be used. (Red colour implies moderate to severe malnutrition, green indicate normal nutritional status and yellow colour indicates mild malnutrition). All children between 1 year to below 5 years should be measured (but not below one or above five years).

Arm circumference include bone, fat and muscle which form the body's protein and energy reserves; they are reduced if the body does not absorb or take in enough food.

Arm circumference increases with age, but from the first to fifth birthday, it does not change much. At this time the body fat is gradually replaced by muscle. Thus, by using this tape with this age group, we do not need to know the exact age of the child in order to know the nutritional status.

•• Method

- Only left arm should be used for measurement.
- First make sure that the child is more than one and less than five years of age
- Let the child's arm hang loosely by its side. Place the tape round the middle of the Upper Arm.
- Note whether the black line (beginning) comes in Green, Yellow or Red colour.
- If black line is in the green, the child is well nourished.
- If black line is in the yellow, the child is mildly malnourished.
- If black line is in the red, the child is severely malnourished.

This is an age independent, simple and easy method of detecting malnutrition.

4. Breast Feeding

Breast milk is sterile, economic, nutritious and specific food for infants. It also has anti-infective properties. The child should be put on to the breast and encouraged to suck within

an hour of delivery. The initial breast milk is called 'colostrum'. It is not harmful as believed by some. On the contrary, it is rich in antibodies, hence it should be fed and not rejected. Only small quantity of milk is produced in the first few days.Sucking helps in increasing milk quantity. It also helps the infant's digestive tract by removing meconium (the first stools of the baby).

The quality of milk is always good regardless of the mother's nutritional status. The quantity of breast milk secreted does not depend upon the breast's size. The quantity is usually sufficient to meet the requirements of a child till 4 months of age. Thereafter, it is important to introduce supplementary feeding in addition to breast feeding. The mother should be encouraged to breast-feed the child as long as possible.

The duration of a feed is not important. Let the baby suck until it releases the breast spontaneously. It is safe to feed 8-10 times a day and even more frequently, if the baby so demands.

Usually, in a mother who is breast-feeding, menstruation is delayed and so also the ovulation which helps in spacing of children.

Participants should be taught regarding cracked/flat nipples, breast-feeding during illness of mother/child, insufficient breast milk due to psychological or other reasons, to make the subject more comprehensive for purpose of training.

Discourage introduction of top feeds too early in childhood and use of bottle feeds or formula feeding.

5. Weaning Food

The breast milk, alone, is not sufficient to meet the caloric and other nutrient requirements of a child beyond 4-5 months of age. At this age, it becomes necessary to introduce semi-solid foods in addition to the breast milk in a child's diet. The breast milk should continue to be the important part of the baby's diet. Items which may be included as weaning foods are roasted and cooked cereals, cooked dhal, ripe bananas, fruits, boiled and mashed potatoes, soft cooked rice, etc.

One weaning food may be tried at a time in small quantities. The quantity may be increased slowly over a period of time. As the child develops a liking for one food, additional weaning foods may be added. Encourage the use of cheap, locally available weaning foods from the 'family pot'.

6. Immunisation

NATIONAL IMMUNISATION SCHEDULE

To whom	When	Vaccine	No.	Route
* Pregnant Women	16 wks-36 wks	TT	2*	Intra-muscular
* Infant	6wks-12 months	DPT	3	Intra-muscular
		Polio (OPV)	3	Oral
	Birth to 12 months	BCG	1	Intra-dermal
	9 to 12 months	Measles	1	Sub-cutancous
* Children	14 to 24 months	DPT	1**	Intra-muscular
		OPV	1**	Oral
	5 years	DT	2*	Intra-muscular
	10 years	TT	2*	Intra-muscular
	16 years	TT	2*	Intra-muscular

* Give one dose if vaccinated previously

** booster dose

Note :

- Interval between doses should not be less than one month.
- The dose of all vaccines is 0.5 ml. except BCG which is 0.1 ml. Polio vaccine is given by mouth in 2-3 drops. Check the level of the vial before use.

The aim of UIP is total coverage of children upto the age of 12 months. Older children may be given vaccines 'on demand'.

The ages indicated for the various immunisations are considered the optimum. However, if there is any delay in starting the first dose, the periods may be adjusted accordingly. It should be the aim that a child before reaching one year of age should have received one dose of BCG, three doses of DPT and three doses of Polio. The BCG, DPT and polio vaccines can be given at the same time. The minimum interval between consecutive doses of DPT and Polio vaccine should be one month. Infants who have missed DPT and Polio vaccines by the first birthday should be given 3 doses of DPT and 3 doses of Polio by two years of age. Children over five years who have not received DPT should be given two doses of DT at an interval of one to two months.

In case of children of 5-6 years (school entry), one dose of DT as a booster will be sufficient if the child has received DPT or DT earlier. Otherwise two doses of DT at an interval of one to two months are to be given.

7. Growth and Development

Growth is defined as an increase in the physical size of the body. Development is defined as increase in skills and

functions. Growth and Development include physical, intellectual, emotional and social development. Growth is a continuous process throughout the childhood and has a range of normal pattern. Various anthropometric measurements of the body can be used to determine growth. However, in community programmes, recording of body weight has been proved to be the best method for assessing the physical growth.

- Physical Growth

The parameters of physical growth in children from the age of 6 months to 6 years are given in the table below, but the figures are rounded up. For convenience weight and height standards for both sexes are being combined.

Age	Ht. in cm.	Wt. in Kg
Birth	48	2.8
6 months	63	6.0
1 year	71	8.0
2 years	83	10.0
3 years	91	12.0
4 years	98	13.0
5 years	104	15.0
6 years	110	17.0

7.2 Development

Development of the child is a continuous process and can be assessed by observing the child for developmental milestones. Some of the identifiable stages of development are reached at the ages indicated below:

- Holds the head up and gives a social smile-2 months.
- Extends hands, catches objects and brings them to the mouth-4 months.
- Sits unsupported-6-8 months.
- Crawls and responds to name-8-9 months.
- Stands unsupported, repeats words, walks with support-10-12 months.
- Walks unsupported, speaks sentences of 2-3 words-12-13 months.

- Monitoring of growth and Development
  - The growth of the children in ICDS scheme is monitored by periodic recording of their weight for age.
  - The following categories of children are weighed once a month:
    - - All children between 0-3 years of age.
    - - All children in Grade III and IV malnutrition till the child has reached above 80% of the expected weight for age.
    - - Children having illness of any type for more than 5 days in a month.
  - Children between 3 years to below 6 years of age will be weighed once in 3 months.
  - Enter the weight of the child on the growth chart accurately.
  - If the child falls in the category of Grade III/IV

malnutrition enter his/her name in 'at-risk' children list and inform the supervisor/ANM/LHV.

- Study regularly the growth chart of each child. The direction of growth curve is more important than the weight at one particular period. If the curve remains flat indicating no weight gain for 3 successive weighings or there is down-wards dip, it should be brought to the notice of the supervisors.

8. Malnutrition

Definition: It is defined as a pathological state resulting from a relative or absolute deficiency of one or more essential nutrients, proteins, minerals, vitamins and energy.

Malnutrition results from interaction of several factors. Ignorance, illiteracy, and poverty lead to inadequate feeding. The traditional beliefs, taboos, food fads, customs and infection are the other major contributing factors to malnutrition.

Malnutrition can be due to specific vitmain/mineral deficiencies. The deficiency of vitamain A in particular, leads to grave complications.

• **Protein Energy Malnutrition (PEM)**

The PEM comprises a variety of very closely interrelated syndromes described below:

•• Kwashiorkor

It is probably the result of consumption of low protein diet providing just enough energy to satisfy the needs of the child and is usually in children aged 1-4 years.

Diagnostic criteria of Kwashiorkor:

- Always present—
  - Pitting oedema.
  - Failure to thrive or gain weight
- Usually present—
  - Changes in the hair (brown, sparse, easily pluckable).
  - Disinclination to play.
  - Loss of appetite, and
  - Diarrohea.

•• Marasmus

It is a clinical form of protein energy malnutrition primarily due to gross deprivation of calorie. Usually occurs in the age group 6 months to 5 years.

- Always Present—
  - Failure to gain weight.
  - Wasting of muscles.
  - Loss of subcutaneous fat.
- Usually present—
  - Irritability, and
  - Good appetite.

•• Marasmic-Kwashiorkor

Children with marasmic-kwashiorkor have mixed clinical features of marasmus and kwashiorkor.

- **Classification of malnutrition**

(Based on weight for age of the child)

Percentage of expected weight	grading	Postion in growth chart
80—100%	Normal	Above the Uppermost line
70—79%	Grade-I	Between lines 1 & 2
60—69%	Grade-II	Between lines 2 & 3
50—59%	Grade-III	Between lines 3 & 4
Less than 50%	Grade-IV	Below line 4

9. Vitamin A Deficiency

Deficiency of Vitamin A is the most common cause of blindness in children aged 1-5 years. It results from diet deficient in foods containing Vitamin A such as milk products and green leafy vegetables. Night blindness is the earliest symptom of the Vitamin A deficiency, later conjunctiva becomes dry and wrinkled. Bitot's spots appear on lateral side of cornea.

Xerosis can be treated with 2,00,000 International Units of Vitamin A given on the day of diagnosis.

- **Prevention of Vitamin A Deficiency:**

Vitamin A solution is given to all the children in age group of 1-5 years in dosage of 1 teaspoonful (2,00,000 units) once in 6 months under National Vitamin A Prophylaxis Programme. All the children in age group of 1-5 years should be examined and record of the amount of Vitamin A administered to each child be maintained.

10. Anaemia in Children

Anaemia in Children is mainly due to iron deficiency but folic acid and vitamin B_{12} deficiencies also play a part. Anaemia can be due to lack of iron in diet or lack of iron absorption from the gut or due to hookworm infestation. Dark green leafy vegetables and cereals are rich in iron. To prevent nutritional anaemia in children, the following drug schedule should be followed.

One tablet of iron and folic acid containing 20 mg of elemental iron (60 mg of ferrous sulphate) and 0.1 mg of folic acid should be given daily for 100 days per year.

11. Vitamin B Complex Deficiency

Deficiency of Riboflavine manifests as angular stomatitis and cheilosis. Usually, the clinical deficiency signs are those of a combination of lack of vitamin B complex. Hence, all B-complex vitamins should be supplemented as assigning deficiency to individual components of vitamin B complex group may be practically difficult.

12. Vitamin 'D' Deficiency

Vitamin D deficiency results in rickets. There is enlargement at the ends of the long bones, particularly wrists and ankles; rounded projections may be seen in the form of 'rickety rosary' on both sides of chest. 'Harrison's sulcus' may be conspicuous.

13. **Supplementary Nutrition: Distribution is as follows:**

Children	Energy (K.cal)	Nutrient (Protein)
- Severely malnourished (Grade III & IV)	600	18-20 g
- Moderately malnourished (Grade II)	300	8-10 g
- Enrolled in nonformal pre-school education (May not be malnourished age 3 to below 6 years)	300	8-10 g
- 'At risk' children (0-6 years)	300	8-10g

The guidelines given below should be followed to select the beneficiaries for Supplementary Nutrition on the basis of upper mid arm circumference:—

- A child having an upper mid-arm circumference not exceeding 12.5 cms (i.e. where the upper midarm circumference is the the red zone of the coloured strip) should be identified as severely malnourished and supplied with therapeutic nutrition (easily digestible, nutrition food, preferably pulverized) at enhanced rates (i.e. supplementation to the extent of about 600 calories and 18 to 20 grams of protein per child per day) in three to four feeds out of which at least 2 feeds should be given at the anganwadi.

- Children with an upper midarm circumference above 12.5 cms but not exceeding 13.5 cms (i.e. where the upper mid arm circumference is the yellow zone of the coloured strip),

should be identified as moderately malnourished and supplied with nutritional supplementation to the extent of 300 calories and 8 to 10 grams of protein per child per day.

- Children whose upper midarm circumference is more than 13.5 cms (i.e. where the upper mid arm circumference is in the green zone of the coloured strip) are not malnourished and do not need nutritional supplements at the anganwadi.

- Children in the age group of 3 years to below 6 years, who, may not be malnourished, but are attending the non-formal pre-school activities will not be debarred from supplementary nutrition but will be given supplementary nutrition along with malnourished children.

- Anganwadi Workers and their helpers will take special care and make all efforts themselves and with the help of village women to ensure that all severely and moderately malnourished children come to the anganwadi daily for nutritional supplements and that all nourished children in the age group of 3 years and above but below 6 years attend non-formal pre-school activities.

- All children below 6 years, identified as severely or moderately malnourished on the basis of upper midarm circumference (i.e. all children whose upper midarm circumference does not exceed 13.5 cms) should to weighed every month to monitor their growth.

- The upper midarm circumference of all children below 6 years should be measured once in three months and if the upper midarm circumference of any of the children, who were not earlier enlisted for supplementary nutrition, is found to be in red or yellow zones in the coloured strip (i.e. not exceeding 13.5 cms.), these children should be added to the list of

beneficiaries of supplementary nutrition. Selection of children on the basis of upper midarm circumference should be done at the time of initial survey. Subsequenly, measurement of upper midarm circumference by coloured strip should be done for all children below 6 years in the months of January, April, July and October.

- When the weight of a child, who has been receiving supplementary nutrition at the anganwadi, shows that the child has acquired normal weight related to his age, the child's parents should be educated that the child no longer needs nutritional supplements at the anganwadi. Educational efforts should be made with the aim that the parents voluntarily withdraw their children, who have acquired normal weight for age, for nutritional supplements at the anganwadi. Such children should however, continue to be given other health and education services.

- The poorest families in every village have been identified as IRDP target familites under the Integrated Rural Development Programmes. Children below 6 years belonging to these families should be enlisted for supplementary nutrition. Special efforts should be made to see that these children get all the health, nutritional and educational services at the anganwadi.

Supplementary Nutrition is given to the children, who are registered at anganwadis, to prevent malnutrition and to treat grade II, III and IV malnutrition.

The supplementary feeding aims at providing approximately 300 kilocalories and 10 gms of protein to children and nearly double this amount to pregnant and lactating mothers in addition to their usual food intake at home.

Note:—

• Supplementary food is to be prepared and served at the Anganwadi itself so that consumption of food by the child is supervised. This will prevent wastage of food which is likely, if the child is permitted to take it home.

• The AWW should try her best to provide a supplementary food which is tasteful and liked by the children, by selecting the proper type of foods, changing the preparations of food and serving it while it is hot. She should consult the supervisor for guidance.

It has been pointed out that at the time of distributing supplementary nutrition to children and mothers at anganwadis, some children who are not identified for supplementary nutrition may be present and it would be difficult to deny supplementary nutrition to such children when they are physically present. If any children, who are not enlisted for supplementary nutrition, are actually given supplementary nutrition at the anganwadis, their number should be separately noted. The monthly progress reports of the anganwadi workers as well as the CDPOs should clearly indicate the number of beneficiaries out of the identified list (in accordance with paras above) receiving supplementary nutrition. At the same time, educational efforts should be continued, with the help of the local leading citizens and the women of the village to educate the community that the supplementary nutrition is required to be given only to those children who are identified in accordance with the given criteria and that the people should desist from sending those children, who are not enlisted for supplementary nutrition, to the anganwadis for receiving supplementary nutrition.

14. Therapeutic Nutrition

• Besides medical care all "at-risk" children need special attention in terms of their nutrition intake. Children with Grade III and IV malnutrition are given special food which is called 'therapeutic nutrition'.

• The food provided as therapeutic nutrition may be different from that for supplementary nutrition. It can be given in semiliquid form, which can be easily ingested and digested by the child and its preparation should be easy. It aims at providing about 600 kilo calories and about 20 g of protein per day. The child may require a minimum of 4 feeds, of which 2 can be given at anganwadi and 2 can be given by the mother at home. The mother must be properly explained about the importance of special care for such a child and necessity of proper feeding at home.

15. Diarrhoeal Diseases

Diarrhoea is passing of at least three or more loose or watery stools per day. Frequent passing of normal stool is not diarrhoea. If mucus or blood is also present, then it is known as dysentery. When a child has diarrhoea, he rapidly loses water and salts due to diarrhoea and vomiting.

The stools of a healthy person contain relatively little water but a person with diarrhoea passes water which contains vital salts (Sodium, Potassium and Bicarbonate). The water and salts must be replaced or the child may die.

When a child has diarrhoea, oral rehydration fluid helps in relieving dehydration and also has positive long-term effects on nutritional status of the child. Rehydration mixture can be made at home. The oral rehydration packets are also available with PHC/Subcentre and commercially.

If possible, the child should receive an extra meal a day for the first week after the attack of diarrhoea.

- Diet during diarrhoea

Do not withhold the food of the child. Give foods rich in energy such as banana, potatoes, dahi, cereals, cooked rice, khichri, dalia, biscuits. Lemon, orange, pineapple, coconut, milk etc. may also be given.

- Signs of Dehydration

- Depression of the anterior fontanelle in infants.
- Sunken eyes.
- Dry mouth.
- Rapid, weak pulse.
- Loss of elasticity of the skin (retracts slowly)
- Sudden weight loss.
- Little or no urine.

- How to prevent diarrhoea

- Breastfeed the child as long as possible.
- Never bottle-feed the child.
- Start giving other foods from four months of age.
- Make sure the child is always eating enough so that his weight goes up every month.
- Always give clean and hot food, cooked just before eating.
- Always use clean drinking water.

- If there is a latrine, use it and keep it clean.
- If there is no latrine, pass stools far away from the house and the source of drinking water.

• Rehydration Solution

Ingredients and composition of Oral Rehydration Salt Solution (ORS) are :

Ingredients	**Quantity**
Sodium Chhloride	3.5 Grams
Sodium bicarbonate	2.5 Grams
Potassium Chloride	1.5 Grams
Glucose	20.0 Grams
Drinking Water	1 litre

The solution will not work unless the right amounts are mixed. If too much of salt is used, the solution may be dangerous. If salt is less, it may be ineffective.

Recently, a plastic spoon is provided in the Medicine Kit of AWWs measuring 0.7 g at one end (for common salt) and 8 g at the other end (for sugar). This is dissolved in two hundred ml. of water. A glass measuring 200 ml is also provided.

ORS should be used within 12 hours and should never be used after 24 hours. The child should be given one glass of ORS (200 ml) for each stool passed.

•• Classification

Diarrhoea is classified according to the severity of the condition as (i) mild (ii) moderate and (iii) severe.

- Mild diarrhoea—The child passes stool 4-5 times a day; the anterior fontanelle may be slightly depressed, the child's skin looks normal.
- Moderate diarrhoea—5-10 stools are passed, eyes look sunken; anterior fontanelle is depressed; return of skin fold is delayed but child passes urine periodically.
- Severe diarrhoea—More than 10 stools are passed in a day; eyes are deeply sunken, anterior fontanelle is very depressed; return of skinfold is delayed; may not pass urine for 12 hours and pulse is rapid and weak.

• Treatment.

•• Mild and moderate diarrhoeea.

- Oral Rehydration Therapy.
- Usual foods and boiled water 3 to 4 times daily.
- When no response to the above treatment in 2 days or appearance of any of the signs given below, refer the case to M.O.

  –– Child has not passed urine for 6 hours.

  –– breathing rate is more than 50 per minute.

  –– hands and feet of the child are cold.

  –– vomiting starts.

•• Severe diarrhoea

These patients should be referred to a doctor or the hospital as soon as possible.

- Feeding

For babies who are receiving animal milk, it may be advisable to dilute milk with equal amount of boiled water for 3 days. Do not give diluted milk for more than 3 days. Older children may have rice, khichri, porridge etc. in gradually increasing quantities as the diarrhoea is relieved.

16. Malaria

Malaria is caused by a parasite transmitted to the child by the mosquito-bite. Malaria is an infection of blood which causes sudden onset of fever with severe chills and rigors (shivering) lasting a few hours. Fever settles down usually with profuse perspiration. The fever returns at regular intervals (36, 48, or 72 hours), depending on the type of malaria. In mixed infections, however, there may not be any clear pattern. Malaria is usually accompanied by headache, bodyache and muscle pain.

Malaria, if suspected, can be confirmed by a simple blood test which is done in PHC on the blood smear, which may be prepared in the field by MPW or malaria worker.

Treatment should be started regardless of whether the test is possible or result of the blood is available. Specific therapy for malaria includes treatment with chloroquine as per dosage given below and paracetamol, for fever and generalised body-aches.

Dosage of chloroquine	(150 mg. base)
Age	Dose
0-1 year	1/2 tab
1-4 years	1 tab
4-8 years	2 tab

When fever is very high, cold-water sponge-bath should be given, till fever lowers down.

WARNING: Do not give chloroquine tablets on empty stomach as it may cause vomiting.

17. Worm Infestations

- Threadworms

Threadworms live in the large intestine and rectum. During the night, worms come out and lay eggs around the anal opening, causing irritation. The worms can be seen in stools as small, thread-like white or pink structures about 1 cm long. Self-infection through fingers and nails due to improper personal hygiene is common.

- Roundworms

Roundworms are large worms living in the intestinal tract. They may cause diarrhoea, pain in abdomen, obstruction and at times even difficulty in breathing. These worms may be multiple and very long (10 to 16 cms) and may be passed in stools. The eggs may be present in food stuffs, vegetables and water leading to reinfection.

- Hookworms

The young larvae of the worm penetrate the bare foot skin and enter the blood circulation, the lungs and finally the small intestine. The worms lodge themselves in the small intestine with the help of the hooks and suck blood leading to anaemia and malnutrition. The eggs are excreted along with faeces and are lodged in the soil.

- Whipworms

Whipworms live in the large intestine and cause abdominal pain and diarrhoea. Eggs are passed in the faeces. Eating of contaminated food and poor personal hygiene lead to repeated infection.

- Prevention

Proper sanitation, personal hygiene, sewage and waste disposal are important steps to prevent worm infestation. Sewage wastes should be disposed off, away from all habitation. The community needs to be educated to use proper sanitary latrines and avoid defaecation in open fields. Drinking water should be clean. Hands should be washed before and after eating. Finger nails should be cut regularly. Vegetables should be washed thoroughly.

- Treatment

One tablet of mebendazole to be taken with water twice daily for 3 consecutive days. The dosage is same for children and adults.

18. **Fever**

When the body temperature is more than 37.2°C, the child's body feels hot, the skin over the face looks red and the child may be irritable.

During fever, it is necessary to uncover the body as much as possible. A child with fever should never be wrapped in clothing and blankets. The child should drink a lot of water. If the fever is very high or temperature more than 39°C, give cold water sponge bath.

Paracetamol tablet is given in case of fever as per dosage given below every 6-8 hours till fever comes down. The medicine should be given with food or milk.

Children	1-3 years	—— 1/4 tablet
	3-6 years	—— 1/2 tablet
Adults		—— 1 or 2 tablets

If malaria is suspected, give chloroquine tablets in addition to paracetamol. When the child has any infection like sore throat or cough, give sulphadimidine/Paed Septran tablets as per schedule.

In case, there is rigidity of the neck or fever does not come down within 2-3 days of treatment, the patient should be referred to a doctor.

If the child develops convulsions or fever remains continuously high (above 39°C) inspite of cold sponging, medication etc, he should be referred to the nearest medical facility. Feeding should not be stopped during fever.

19. **Headache and Bodyache**

Headache and bodyache are often associated with any type of fever. If headache is severe, check if the child is able to make neck movement freely. If not, refer to the nearest medical facility.

If the movements of the neck are normal, give paracetamol tablets as per dosage given below 3-4 times a day.

Children	1-3 years	— 1/4 tablet
	3-6 years	— 1/2 tablets
Adults		— 1-2 tablets

If patient does not get relief with the above treatment within 2-3 days, refer to the nearest medical facility.

20. **Cough**

Cough is not an illness by itself, but is a symptom of some other sickness affecting throat, lungs and airway tubes in the chest.

When the cough is of recent origin and there is associated sore throat or slight fever, treat the person with sulphadimidine/Septran tablets as per dosage below. If cough has been present for a long time, or when blood is also coughed out, refer the person to the nearest medical facility.

Sulphadimidene dose schedule

Children: 1-4 year 1/2 Tab every 6 hrly x 5 days

4-6 year 1 Tab every 6 hrly x 5 days

Adults : 1st dose of 6 Tabs.

Then 2 Tabs., every 6 hrly x 5 days

Septran dose schedule

Children: 0-1 year 1 Paed. Septran Tab twice daily x 5 days

2-5 years 2 Paed. Septran Tab. Twice daily x 5 days

6-12 years 4 Paed. Septran Tab twice daily x 5 days

Adults: 2 Septran Adult Tab twice daily x 5 days

Patient should drink a lot of water and if not relieved within 5 days of treatment, refer to the nearest medical facility.

Also treat the fever by giving paracetamol (details given earlier).

21. Scabies

Scabies is an infestation of the skin causing itching and lesions that appear all over the body, especially on the skin between fingers, wrists, around the waists and genitals. Lesions are caused by mite which make lesions under the skin.

If one person in the family has scabies, everyone in the family should be treated.

- Treatment

All the infected members of the family should be treated at the same time.

- Give a thorough bath with soap and water.
- Apply 25% benzyl benzoate emulsion for three consecutive days all over the body except the face. Special attention should be paid to the finger webs, axilla, groins, genitals in males and breasts in females. After three days, give a bath with soap and water. All the clothes that are taken off, are boiled in water. Bed linen (sheets, pillow covers and mattresses etc.) are exposed to the sun light for a day.

If the skin lesions are infected, are red and have pus, do not give this treatment but refer to medical facility for proper treatment.

Scabies can be better prevented by personal cleanliness, bathing and change of clothes regularly.

22. Sore Eyes

Infection of the outermost lining of the eyes which causes redness, burning sensation and at times, pus in one or both eyes. This condition is known as 'conjunctivitis'. There is watering of the eyes. The eyelids often stick together after sleep.

- Treatment

Boil one glass of water with a pinch of salt and then let it cool. Boil a few pieces of cotton swabs in a small bowl separately and let them cool. Ask the person to lie down. Wash the hands with soap and water. Take the boiled water in a cup and pour gently in the corner of the eye near the nose. Discard the dirty water. Take a piece of boiled cotton and wipe the eye gently with one stroke, starting from near the nose towards the ear. Do not use the same cotton piece again. Similarly, clean the other eye also.

After this, pull down the lower eyelid of one eye and put in 2-3 drops of 10 percent sulphacetamide eyes drops (20% for adults). Repeat this procedure in the other eye also. Instil the drops 3 times a day.

Note: If rash or itching starts on the face, stop the above treatment and refer to the nearest medical facility.

- Prevention:

Proper hygiene, including regular washing of face, is necessary. Sore eye can spread from one person to another. So do not let a child with sore eye play or sleep with others; use separate towel, wash the hands after touching the sore eyes.

23. Stye

This is a swelling on the eyelid near the eye lashes. Treatment is same as for sore eyes.

24. Xeropthalmia (Vitamin 'A' Deficiency)

This disease is common in pre-school children. At first, the child cannot see as well in dim light as other people can. Later, he develops dry eyes (Xerosis); the white of the eyes loses its shine and begins to wrinkle. Patches of grey white soapy plaques (Bitot's spots) may be present. Further, the xerosis can get worse and may affect the eye portion (cornea) through which the child sees, leading to scarring and blindness.

- Prevention

Breast feed the child as long as possible. After first 6 months, give the child dark green leafy vegetables, fruits, other vegetables and whole milk etc.

Give Vit. 'A' solution (200,000 IU) once in 6 months from the age of 1 year to 5 years of age.

- Treatment

If the child already has any of the signs and symptoms described above, give one dose of Vit. 'A' solution and refer for immediate attention to the Medical Officer.

25. Trachoma

Trachoma is a chronic form of conjunctivitis (sore eye) that slowly gets worse. There is no obvious redness but watery eyes may be an early symptom in the disease. Later small pinkish grey lumps are formed on the inner side of the upper eye lid. If not treated early, it can lead to blindness. It spreads by flies and needs good personal hygiene and care for prevention of this disease.

- Treatment

Wash the eyes with clean boiled and cooled water twice every day. Put tetracycline eye ointment inside the eyes from the corner of the nose to the ear by pulling the lower eyelid downwards, three times a day continuously for 1 month. The child may be taken to the doctor for confirmation and continued treatment.

26. Anaemia

A person with anaemia has 'weak' blood. It leads to decreased work capacity, tiredness, breathlessness etc. Anaemia can be detected by the following symptoms:

Pale skin;

Pale insides of eyelids;

Pale gums;

Shiny smooth tongue;

Whitish finger nails;

Weakness and fatigue;

Anaemia occurs in young children and pregnant women more frequently. It can be avoided by taking foods rich in iron. Bajra and ragi have good amount of iron. Green leafy vegetables, especially amaranth, spinach, beans and peas are other sources of iron. Jaggery also has iron. Animal foods are rich in iron. Children and pregnant women should be encouraged to take iron-rich foods.

- Prophylactic Treatment

During pregnancy, women should be given iron and folic acid tablets (IFA tablet) containing 60 mg of elemental iron and 0.5 mg of folic acid every day for 100 days.

Children should be given folifer tablets containing 20 mg of elemental iron and 0.1 mg of folic acid every day for 100 days in a year. These tablets are distributed under National Nutritional Anaemia Prophylaxis programme.

In case of women and children having severe anaemia. refer them to the sub-centre or to the medical officer for appropriate treatment.

27. Cuts, Scratches and Wounds

To treat a cut, scratch or wound, wash the hands with soap and water. Then wash the wound with soap and water or antiseptic solution. Clean out all the dirt from the wound. Lift up and clean the under surface of skin flaps. Never put alcohol or Iodine directly into a wound before cleaning. After cleaning, apply 2 percent solution of iodine on the affected part with a cotton swab and leave it to dry.

If necessary, give aspirin or paracetamol for fever, pain and sulphadimidine/Paed. Septran for infection. To avoid the wound from getting dirty apply some clean gauze or loose cotton and bandage lightly. The bandage and the cotton should be changed every day.

If the wound is very large and bleeding, refer to the nearest medical facility. Advise all patients with cuts or wounds to get a repeat dose of tetanus toxid injection from the nearest medical facility.

28. Boils and Abscesses

A boil or an abscess is an infection which forms a small collection of pus under the skin. It is painful and the skin around it becomes red and hot. It can cause swollen lymph nodes in the neck, axilla or groin region. Fever may also be present.

- Treatment

Put hot compresses over the boil several times a day. Let the boil break open by itself. After it breaks, continue applying hot compresses. Allow the pus to drain. Wash the area with antiseptic solution gently and let the skin dry. Never press or squeeze the boil. Apply 2% solution of mercurochrome or gentian violet on the boil or abscess. Give sulphadimidine/Paed. Septran tablets as per dosage below:

Sulphadimidene dose schedule

Children : 1-4 year-1/2 Tab every 6 hrly x 5 days

4-6 year-1 Tab every 6 hrly x 5 days

Adults : 1st dose of 6 Tabs

Then 2 Tabs every 6 hrly x 5 days

Septran dose schedule

Children : 0-1 year—1 Paed Septran Tab twice daily x 5 days

2-5 years—2 Paed Septran Tab twice daily x 5 days

6-12 years—4 Paed. Septran Tab twice daily x 5 days

Adults —2 Septran Adult Tab twice daily x 5 days

Ask the patient to drink a lot of water. Treat the fever, if present. If no relief within 3 days, refer to the nearest medical facility.

29. Care of Drugs

Use of drugs saves lives, but they can be dangerous also. One should, therefore, be very careful in handling them. The under-mentioned precautions must always be observed:

- When you give a drug to a patient, write its name and dose clearly and instruct the patient or his attendant about its use.
- Keep the drugs locked safely in a cupboard, so that a child in the AW does not consume them accidently.
- Keep the drugs in a separate container so that they do not get mixed.
- Ascertain the exact strength of each drug when a new stock arrives.
- Prescribe the drugs given to you, only for the number of days instructed. Keep a record of the drugs and the dose administered.
- Check the dose of the prescribed drug, every time even if you are sure that you know the dose by memory.
- If the age of the child is in doubt, use the dose meant for the next lower age group.
- Give the drugs for the number of days indicated even if the patient looks well. This is essential for complete cure.

  If the drugs given by you produce adverse effects e.g. skin rash, note down the name of the drug and the reaction on the patient's card and stop the drug immediately and refer to MO.

Every time you prescribe a drug, you must explain to the mother how it will help e.g. you can say that aspirin is being given to relieve pain. Tell the mother to give the drugs for the correct duration in the dosages advised. Show the mother, how to give the drug to the child by giving the first dose in the AW. If the patient vomits the drug, repeat the same dose.

Ask the mother to report to you after a specific number of hours or days, so that you may assess whether the child needs any change in the drug. Instruct the mother to keep drugs at places inaccessible to the child, so that he does not take excess of drugs because he likes the taste.

Also instruct mother that the lotions and antiseptics are to be applied to skin only and may be dangerous if ingested or applied to eyes.

B. SERVICES TO THE WOMEN

Women comprise an important section of any population and they have a major role to play in child development. Under ICDS, the groups of women who get special attention are:

- Pregnant women:
- Lactating mothers (first six months);
- Women in reproductive age group (15-44 years);

The services given to women are:

– – Supplementary nutrition including folifer tablets to pregnant and lactating women:

– – Antenatal and postnatal services including tetanus toxoid immunisation and advice on family planning;

– – Nutrition and Health Education.

(a) **Supplementary Nutrition**

	Energy (Kcal)	Proteins (g)
- Pregnant women (2nd & 3rd trimester)	600	18-20
- Lactating women (first 6 months)	600	18-20

The reason for supplementing the food intake of pregnant and lactating women is to improve the nutritional status of the mother and to increase the birth weight of the child yet unborn and also to build up enough body stores so that the mother can breastfeed the baby without compromising her own nutritional needs.

It has been estimated that more than 50% of Indian women suffer from anaemia during pregnancy. Under the National Nutritional Anaemia Prophylaxis Programme, pregnant women are to be given folifer tablets containing 60 mg of elemental iron (180 mg of ferrous sulphate) and 0.5 mg of folic acid every day for 100 days during second and third trimester of pregnancy. Those who are suffering from anaemia may have to be given further iron therapy after determining the severity and cause of anaemia. The following guidelines should be followed for selection of beneficiaries:

Pregnant women and nursing mothers belonging to the families of landless agricultural labourers, marginal farmers (holding not exceeding one hectare), scheduled castes and scheduled tribes and other poor sections of the community (total monthly income of all members of the family not exceeding Rs. 300) should be enlisted for supplementary nutrition. In other

cases, guidance of the ANM/Doctor should be sought. In other words, a pregnant woman/nursing mother not belonging to the above mentioned categories, can be enlisted for supplementary nutrition if the ANM or the Doctor so advises on medical grounds.

Correct identification and enlistment of beneficiaries of supplementary nutrition in each anaganwadi area is a very important task. Where this work has not yet been correctly carried out, a fresh exercise should be done to complete this work expeditiously. Each Child Development Project Officer and the Medical Officers in the PHC should have a clear consolidated picture of all children and mothers, identified and enlisted for supplementary nutrition according to the guidelines given and periodically review whether all the enlisted children and mothers are getting supplementary nutrition or not. Continuous efforts are necessary to ensure that all the identified and enlisted children and mothers are given supplementary nutrition. Continuous and close attention is especially needed for meeting the needs of the severely malnourished children and the children needing hospitalisation.

(2) **Antenatal and Postnatal Services**

The primary responsibility of providing such services lies with the staff of the Primary Health Centre in rural areas and urban health centres. The ANM and the LHV render these services directly. Stress should be on early seeking of antenatal services and regular check-up to direct 'high-risk' pregnancies for appropriate referral to provide hospital or domiciliary delivery as the case may be. Anganwadi Workers should enroll the pregnant women so that ANM can ensure wider coverage.

- Identification of "At Risk" mothers

"At Risk" mothers are those who fall under one or more of the following categories:

- Those whose pre-pregnancy weight is 38 kg or less.
- Those whose post-pregnancy weight is 40 kg or less at 20th week.
- Or, if contacted late, weight less than that arrived by adding 1 kg per month, to 40 kg weight after 20th week of pregnancy.
- Height 145 cms or below.
- Primipara.
- Have twin pregnancies.
- Previous history of still-births, abortions, antepartum and postpartum haemorrhage or eclampsia.
- Previous history of early neonatal deaths.
- History of previous caesarian or forceps deliveries.
- Age above 35 years or below 18 years.
- Suffering from TB, severe anaemia, heart disease or diabetes.
- Have conceived after treatment for infertility.
- Have had 4 or more pregnancies.

- Ante-natal Care
  - A minimum of 4 physical examinations should be done during pregnancy of which one must be after 36 weeks

of pregnancy. The number of visits may have to be increased in high-risk cases.

- Give immunisation with tetanus toxoid as per schedule.
- Give folifer tablets for anaemia prophylaxis as per schedule.
- Appropriate advice regarding diet.
- Advise for preparation for the arrival of baby.

Post-natal Care

Two visits must be paid to the mothers within first 10 days of delivery. Specific advice regarding care of the breast, feeding of colostrum and breast-milk should be given. This opportunity should be utilised to activate the mothers to accept family planning methods.

On an average an Indian mother secretes 600 ml of milk daily, which yields about 400 Kilo calories and 7 g. of protein. Though breast milk is adequate food for the child upto 4 months of age, the mother should be encouraged to breast-feed the baby as long as possible.

3. Tetanus Toxoid

During the first pregnancy, the mother should be given 2 doses of tetanus toxoid immunisation at an interval of 4-6 weeks. The doses should be given between 16-36 weeks. In case of subsequent pregnancies, single booster dose in the second half of pregnancy need only to be given.

4. Lactation

A lactating woman should take extra diet so that the breast milk secretion is adequate. It must be remembered that

a malnourished woman probably secretes a smaller volume of milk, especially if she has borne several children. If a mother has a very poor diet and she gives her baby nothing except her own milk, the child may stop gaining weight sooner than usual.

Lactation seems to be physiologically well protected. It does not decline with woman's diet. Milk secretion is maintained at the expense of the woman's reserves and only when these are used up her milk is affected. Secretion of breast milk depends upon age and nutritional status and mental attitude of the mother.

Lactating women should eat dark green leafy vegetables every day. They should also add ghee/oil to the food.

5. Population Education and Family Welfare

It is very important to train all levels of functionaries on the need for a small family norm. Direct information on family planning should be given. The health functionaries including the anganwadi workers can play an useful role by laying more emphasis on positive health, child survival and strained resources of a large family for family planning education. Some of the relevant messages are:

- Few children means more of everything for each child.
- There should be a gap of at least 3 years between children to improve the health of the mother and to give undivided attention to the growing child (child spacing).
- Male or female contraception methods, their availability and advantages.
- Adopt permanent methods after 2 children viz. sterilization.

6. Nutritional requirements for Mother and Child

Food is the chief source of essential nutrients which the body needs for well-being. Balanced food is indispensable for health at all stages of life and for satisfactory growth during infancy, childhood and adolescence. Food is made of protein, carbohydrate, fat, vitamins and minerals.

Energy value of food is expressed in terms of Kilo-calories. Daily energy requirement for children is approximately as follows:

0-5 Months	118 Kcal/kg of body weight
6-11 Months	108 Kcal/kg of body weight
12 months	1000 Kcal

Thereafter, add 100 Kilocalories for each year of age till six years, to base of 1000 Kilocalories required at the age of 1 year.

Recommended dietary protein allowances for infants and children by ICMR, 1989, are as follows:

0-5 Months	2.0 g/kg of body weight
6-11 Months	1.7 g/kg of body weight
1-3 Years	23 g/day
4-6 Years	31 g/day

Recommended dietary intake of nutrients of expectant and lactating mothers

The foetus gains maximum weight during the last trimester of pregnancy. It had been seen that adequate amount of calories taken during last trimester of pregnancy helps to

increase the birth weight. Supplementary nutrition should be started in pregnancy and be continued for 6 months after delivery.

Category Women (Sedentary)	Kcal (cal)	Prn (g)	Cal (g)	Iron (mg)	Vit 'A' (Retinol) (µg)	Thiamine (mg)	Vit C (mg)
1. Non-pregnant	1875	50	0.4	30	600	0.9	40
2. Pregnant	2175	65	1.0	38	600	1.1	40
3. Lactating	2450	75	1.0	30	950	1.2	80

Emphasis should be on cereals, pulses, green vegetables, milk and milk products. Give iron and folic acid tablets. If adequate amounts of protein are taken in the form of pulses and cereals, milk is not necessary.

Commonly available low cost vegetables, pulses and cereals provide adequate amount of energy and protein. Energy and protein content of 100 g. of edible portion of common foods is as follows:

Per 100 g of edible Portion	Energy in Kcal	Protin in g.
Whole wheat flour	341	12.1
Rice	345	6.8
Bengal gram	372	20.8
Soya bean	432	43.2
Groundnut	567	25.3
Milk (cow)	67	3.2
Milk (buffalo)	117	4.3

Mutton	194	18.5
Egg	173	13.3
Potato	97	1.6
Banana	116	1.2

HEALTH AND NUTRITION EDUCATION MESSAGES

1. Better Child Care

- General advice

- Breast milk is the best milk for your baby.
- Breast-feed your child as long as possible.
- Continue to feed your child even when the child or mother is ill.
- Start feeding your child semi-solid foods like porridge, khicli, soft-mashed fruits and vegetables etc. when he is 4 to 5 months old.
- Your child can eat only small quantities at a time. Feed your child 5 to 6 times a day.
- Give plenty of water to the child when he has diarrhoea.
- All utensils used for cooking and feeding should be clean.
- Keep food and water covered and protected from dust and flies.
- Immunisation protects your baby from vaccine preventable disease. Get you child immunised.

- Weigh your child every month and watch him grow.
- Take your child regularly to the clinic for a health check-up.
- Have only two children. Space the children at least two or three years apart.

• Breast Feeding

- Breast-feed the child soon after birth to give him 'colostrum'.
- Colostrum is rich in nutrients and helps development of immunity in the child.
- Breast-feed as frequently as the child demands.
- Continue breast-feed even when the mother or the child is sick or has diarrhoea.
- Continue breast-feeding as long as possible.
- Breastmilk is the best natural food for infants.
- Breastmilk contains the required nutrients in the right proportion.
- Breastmilk is clean and protects your child from many infectious diseases including diarrhoea.
- Breastmilk is readily available and requires no special preparation.
- Breastmilk does not have to be purchased and is economical.
- Breasmilk is always available at the correct temperature.

- Prolonged breast-feeding helps in child spacing.
- Breast-feeding promotes love and security.
- Breast-feeding helps the mother to reduce excess weight acquired during pregnancy.

• Weaning (introduction of semi-solid foods)

- In addition to breastmilk, your baby needs additional food from 4 to 6 months onwards.
- Give your baby semi-solid foods like kheer, khichdi, soft mashed fruits and vegetables etc. from 4 to 6 months onwards in addition to breast-milk.
- Introduce only one food at a time and give it regularly for a few days until the baby learns to like it.
- Start with small quantities and gradually increase the quantity.
- Feed your baby with semi-solid food five to six times a day in addition to breastmilk.
- No spicy foods should be given to the young baby.
- If the baby dislikes a particular food, do not force him/her to eat it. Discontinue or substitute it. You can try it again later.
- Introduce all new foods cautiously if the baby has frequent bowel upsets.
- Stop immediately foods that give allergic reactions and consult medical personnel.
- Do not give your baby food that has been cooked and kept overnight.

- Serve foods in a separate plate so that you have good idea of the quantity the baby has eaten.
- Wash your hands and the baby's hand before feeding.
- Keep clean all the utensils used for cooking and feeding the baby.
- Keep flies off the food and keep it covered.
- Always use clean and safe water to drink.

• Immunisation

- Immunise your child and protect him from whooping cough, tetanus, tuberculosis, poliomyelitis, diphtheria and measles.
- Immunise your child on time.
- Immunisation is effective only when all the doses at suggested intervals are given.
- Consult health functionary/AWW for correct advice on immunisation.
- Immunise pregnant women against tetanus.
- Immunisation services are available free at health centres/AW/dispensaries/hospitals, etc.
- Get the vaccination done only from reliable sources.
- Motivate your neighbours and friends to get their children immunised.

• Watch your child grow.

- Weigh your child every month.

- Regular weight gain is a good indicator of rate of the growth.
- Use a growth chart to check the child's rate of growth during the first five years of life.
- Poor growth rate is a reminder to parents and health workers about the need for better child care.

2. **Care of the Pregnant Woman**

- A pregnant woman must prepare for the birth of her baby. Good care begins before the baby is born.
- A pregnant woman should eat more than what she eats normally to nourish herself and the growing baby.
- A pregnant woman should eat plenty of green leafy vegetables.
- A pregnant woman should have regular health check-up.
- A pregnant woman with health complaints should immediately see the doctor.
- A pregnant woman should be immunised against tetanus to protect herself and her baby.
- A health centre is a safe and clean place for delivery.
- A pregnant woman should avoid, as far as possible, taking drugs during pregnancy and lactation.
- A pregnant woman should understand all about breast-feeding.

3. Sanitation and Health Habits

- Sanitation
  - A clean home leads to good health and absence of diseases.
  - Water from unprotected areas, if consumed, can lead to diarrhoeal diseases. Always Drink Clean Water.
  - Boil water if the water is not clean.
  - Protect your sources of water.
  - Always collect and store water in a clean container.
  - Cover all food and water to protect it from flies and dirt.
  - Collection of waste water and solid waste gives rise to unpleasant odours, mosquito and fly breeding and attracts rats and dogs.
  - Flies, mosquitoes, dogs etc, can spread disease.
  - Waste water can be safely disposed off by having a kitchen garden or a soakage pit.
  - Refuse should be disposed off by burying, composting or burning.
  - Sanitary latrine or using a pit and covering it with soil, is a safe and hygienic way of disposal of human excreta.
  - Keep your house and surroundings clean.

- Health Habits
  - Be regular in your daily routine.
  - Go to bed early and rise up early.
  - Take bath every day and keep your body clean.
  - Cut your nails short and keep them clean.
  - Brush you teeth every day in the morning as well as at night after dinner.
  - Always wear clean clothes.
  - Have regular health check-ups.
  - Develop regular eating habits.
  - Eat and drink only clean and safe food and water.
  - Wash your hands before eating.
  - Wash your hands after visiting the toilet.
  - Keep your surroundings clean and beautiful.

4. Common Diseases

- Diarrhoea Management.
  - When a child has repeated loose watery stools, he has diarrhoea.
  - Diarrhoea is not a disease but a symptom of many illnesses.
  - Diarrhoea is usually caused by unclean water and food, dirty habits and surroundings.
  - A child with repeated loose stools may develop dehydration.

- Give the child plenty of fluids to drink. The water he looses, must be made up. Coconut water, rice water, light tea can also be given.
- Diarrhoea can be treated successfully at home.
- Make the special drink at home using salt and sugar. Two fistfuls of sugar, one pinch of salt (three finger pinch) in one litre of water. Give the child one glass of sugar-salt solution after every watery stool.
- Continue breast-feeding even when the child has diarrhoea.
- Continue to feed the child as usual. The child needs food to stay strong and to fight diarrhoea.
- If the child vomits and is not getting better, consult the health worker.

Health of Eyes

General Care of eyes

- Wash your eyes and keep them clean.
- Keep away from persons with sore eyes.
- Protect the eyes from dust, dirt, smoke and bright sunlight.
- Use clean and separate towel or handkerchief for the eyes.
- Do not rub the eyes with dirty fingers.
- Personal cleanliness and hygienic care will protect your eyes and prevent infections.
- Avoid use of 'kajal' or 'surma'. If used always use clean individual applicator.

- If the eyes appear swollen or watery, consult your doctor immediately.
- Avoid self-medication. Get the eyes checked periodically.
- Protect your eyes from injuries.
- Keep knives, needles, pens, pencils and other articles with sharp edges away from children.
- Select toys which do not have pointed ends.
- Games like guli-danda, fire crackers and bow and arrow should be discouraged.
- Child below six years should not be encouraged to read fine prints. It may strain the eyes.
- Do not neglect eye strain.
- Take care that there is enough light while reading.
- Diseases such as diabetes and syphilis should be effectively treated as early as possible because they can lead to eye complications.

●● Prevention of VItamin 'A' deficiency

- Vitamin 'A' is important to keep your eyes bright and healthy.
- Vitamin 'A' deficiency is a major cause of blindness amongst children.
- Children, pregnant women and nursing mothers should eat foods rich in Vitamin 'A'/carotene.
- Yellow and green leafy vegetables such as palak, carrot etc. are rich in Vitamin 'A'/carotene.

- Newborn babies should be given colostrum, the yellowish milk which is rich in Vitamin 'A'.
- Massive doses of Vitamin 'A' by mouth every 6 months can protect the child from blindness.
- If the eyes look dry and dull or the membrane of the white part of the eyes is wrinkled consult a doctor immediately.

- Goitre
  - Goitre is a disease of the thyroid gland characterised by a swelling in the neck.
  - Goitre is caused by deficiency of iodine in the diet.
  - Goitre affects people of all ages but it affects the children most.
  - Goitre hinders both physical and mental growth.
  - Goitre in pregnant women can lead to birth of deaf and mute children.
  - Goitre can be prevented by regular use of Iodised salt.
  - Iodised salt prevents further increase in size and even reduces the size of an early goitre.
  - Iodised salt is available at approximately same prices as common salt.
  - Consumption of iodised salt is safe.

- Care of the ears
  - Do not bathe in dirty rivers and ponds.
  - Do not put pins and needles in your ears.

- Do not expose ears to loud noise.
- Do not hit on the ear.
- Do not put hydrogen peroxide in a child's ear.
- Do not neglect cough and cold.
- Learn the early signs of deafness.

• Malaria

- Malaria is spread through mosquito bites.
- Mosquitoes breed in stagnant water.
- Do not let any water collect in the house, verandah, open yards, garden, lawns, etc. as mosquitoes can breed in any water collection.
- Do not keep any empty containers like tins, buckets, bottles, tyres etc. in the open where water may collect.
- Do not keep water tanks/drums on the roof of houses uncovered.
- Do not allow continued presence of water in any place such as tanks, cisterns, air coolers, flower vases etc. for more than 6 days at a stretch.
- All water containers such as tanks, cisterns, air coolers, buckets, flower pots, should be emptied and scrubbed dry once a week.
- Get all leaking taps and hydrants repaired.
- House drains must be maintained properly, repaired and cleaned.
- Blocked roof gutters should be cleaned specially before the rains.

- To prevent mosquitoes, keep the neighbourhood clean and use mosquito nets.
- If you suspect malaria or suffer from any fever, go to a Health Centre for a blood test.
- Start treatment immediately. The treatment and examination of blood for malaria is free.
- Take tablets as a preventive measure only after consulting the health worker.

• Tuberculosis

- Tuberculosis is an infectious disease.
- Tuberculosis is preventable and curable.
- Tuberculosis is not hereditary.
- Tuberculosis spreads through sputum and cough.
- Persistent cough is an important symptom of tuberculosis.
- Tuberculosis is completely curable with regular and continuous treatment.
- Facilities for diagnosis and treatment are available at general hospitals and other health clinics.
- Protect all infants and children from tuberculosis by BCG vaccination.
- Avoid spitting on the floor. Practise good hygienic habits.

• Leprosy

- Leprosy is like any other disease.

- Leprosy is caused by germs. It is neither hereditary, nor a curse of God.
- Leprosy can occur at any age, in man or woman.
- Learn to detect leprosy early. Early signs of leprosy are discoloured patch, loss of sensation, tingling sensation in hands and a thickened nerve.
- Most of the leprosy cases are non-infectious.
- Leprosy is completely curable with regular treatment.
- Infectious cases can be made non-infectious by prompt and adequate treatment.
- Early detection and regular treatment prevent deformities and disabilities.
- Help to overcome fear, encourage early detection and sustained treatment.
- Leprosy patients can continue to live at home and do normal work while under regular treatment.
- Do not isolate leprosy patients. Accept them in the family and in the community.

4. Motivation of functionaries in ICDS projects

One of the major objectives of interaction of functionaries of ICDS at different levels is to stimulate them for commitment to the programme and efforts to its successful implementation. A social approach is being followed at each level and every conference at sector CHC, district and the state headquarters. The activity related to motivation cannot be described in quantitative terms, but it is essential and has proved to be very useful in ICDS.

5. Financial Assistance

With the introduction of new monitoring system from 1st March, 1985, the procedure of releasing the grants-in-aid of Chief District Adviser (CDA), District Adviser (DA), Project Adviser (PA) and the Sectoral Adviser (SA) for monitoring and continuing education has been revised and streamlined in States/ UTs on the following lines:

Sectoral Meetings: Officer Incharge of a sector of PHC (ICDS Sectoral Adviser) will be paid an honorarium of Rs.20/ - per sector each month for sectoral monitoring and continuing education. AWWs will draw their TA and DA from CDPO.

PHC level Meetings: The Medical Officer-in-Charge PHC (Project Adviser) will be paid Rs.25/ -as an honorarium for the sectoral meeting for himself and Rs.25/-as contingency expenses including clerical assitance for compiling the MMRs.

The District Adviser: He will be paid Rs.30/- for each project level continuing education and monitoring meeting with a maximum of Rs.90/- if he takes up three project level meetings. He will also be paid Rs.10/- per month for postage and contingency.

The Chief District Adviser: He will be paid Rs. 50/- for monthly continuing education and monitoring meeting and Rs.25/- for postage and contingency.

The PHC level and the district level meeting of ICDS will be held on the same date and time as the routine health meetings, therefore no TA and DA will be required separately.

A new system of disbursement of honoraria to different level functionaries in ICDS viz. Chief District Advisers, District Advisers, Project Advisers and Sector Adviser, has been

implemented from 1st January 1989 in selected states of the country. The new system facilitates accounting procedures at the Central and district level and also helps in upto date distribution of honoraria to the most peripheral ICDS functionaries.

Under the revised system a sum of Rs.500/- (Rupee Five hundred only) has been remitted to the Chief District Advisers (ICDS) of the State/UTs for opening a Savings Bank Account in any nationalised bank in the district town and furnish the particulars thereof to the CTC. The honorarium and contingency amount as becomes payable quarterly to CDA/DA/PA/SA are despatched directly to the relevant branch of the bank with instruction to credit the amount in the account of the CDA under intimation to the Chief District Adviser concerned enclosing a statement showing the break-up of the amount due to various ICDS functionaries. In cases where the Chief District Adviser has not furnished the requisite details of the bank account, the cheque as well as the break-up statement is sent to him directly reminding him to open the bank account and furnish the particulars thereof.

1. Method of Payment of Honorarium

INTEGRATED CHILD DEVELOPMENT SERVICES

Central Technical Committee, ICDS, Department of Women & Child Development, Ministry of Human Resource Development, R.K.Puram Block No. 1, Wing 3, 2nd Floor, Post Bag No. 16, New Delhi-110066.

M. C. Gupta
Accounts Officer

No. F.2-1/ICDS/

Dated_____

The Chairman, CTC has desired that the Advisers, who

are submitting monthly reports should be paid their honorarium and contingency in time. The present system of payment can be improved. It has, therefore, been decided that the quarterly honorarium and contingency amount will be remitted directly to your bankers under intimation to you. The following procesure will be immediately followed to facilitate the timely payments to advisers:

- The Chief District Adviser will open a Savings Bank Account in the State Bank of India with Rs.500/- for which the bank draft is enclosed. Each CDA is required to fill up the post-card providing the particulars of the Account Number etc, immediately after opening the account. This self-addressed post-card will be sent to each CDA along with the draft to open the account. Existing account in any other name, for receiving the ICDS grant, will be closed and balance, if any, transferred to this account in the name of the CDA, ICDS.

- In future, for every quarter, the amount of payment for CDA, DA, PA and SA will be calculated on the same pattern as now. The amount calculated for the payment will be sent from the CTC Corporation Bank account at New Delhi in the CDA's State Bank of India Savings Bank Account at the District Headquarters, for crediting it in the Account Number which the CDA will be providing to the CTC through the post-card.

- This procedure will avoid the delay which occurs in the process of asking you to send the pre-receipt as well as which is related to encashment of the cheque. Further, the CTC will not require any receipt from you for the money which will be transferred every quarter to your account in the State Bank of India.

- You will receive the intimation from us that we have credited the quarterly expenditure grant in your account. You will kindly withdraw that money from the bank and as per present procedure distribute it to the DA, PA, SA and for contingency expenditure. While the CTC is trying to improve the system of payment, all depends on your active cooperation and particularly on the willing assitance of your office staff.

- When you are transferred to the other District, please do remember to give the charge of the CDA account and other papers to the incumbent who takes over from you as the Chief Medical Officer of the District and will, automatically, become the Chief District Adivser for ICDS in that district.

- Since it is Government of India official account for the National Programme, you can show this letter to the Manager of your Branch of the State Bank of India. He is not supposed to take any bank charges from you.

With regards,

Yours sincerely

(M. C. GUPTA)
Account Officer

Encl: As above

6. Appendices

FORMAT - I

AWW'S MONTHLY MONITORING REPORT FORM:

1. Month_____ 2. Year_____

3. Name of the Village where AW is located_____

4. S. No. of AW_____

5. (a) Total Population of the AW area_____

   (b) Total Population of Children 0 to 6 years_____

6. Supplementary Nutrition was distributed at AW:

   (a) Very Regular (21+days) (b) Moderately Regular (15-21 days) (c) Irregular (<15 days)

7. Quality of Supplementary Nutrition:—
   Good/Acceptable/Poor.

8. Number of malnourished Children-as compared to last month. (Please Tick)

   —Grade II Increased/Decreased;
   —Grade III/IV Increased/Decreased

9. Immunisation carried out in the month. (Please Tick)

BCG	DPT	Polio	Measles	DT	T.T.
Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

10. Other important events: (Pl. Tick)

Incidence as compared to last month	Increased	Decreased
a) Diarrhoea		
b) Live births		
c) Still births		
d) Total deaths		
i) 0 to <1 year		
ii) 1 to <3 year		
iii) 3 to <6 year		
iv) Pregnant Women during delivery		
e) Total No. of:		
i) Pregnant Women		
ii) Lactating Women		

O.R.T. advised Yes/No.

11. Reviewed by Date Signature

i) ANM/MPHW(F) _____ _____

ii) Sector MO/LHV/HA (F) _____ _____

Note: The report is for the whole month (1st to the last day). The report should be discussed with ANM & LHV and finally submitted to the sector MO at the sectoral meeting.

FORMAT - 2

SECTOR MEDICAL OFFICER'S MONTHLY REPORT ON SECTORAL MONITORING AND CONTINUING EDUCATION FOR THE MONTH OF_____

1. Name of the PHC/CHC_____
2. Sector No. I/II/III/IV (Circle your sector No.)
3. Total Population of:
   (i) your sector_____
   (ii) Reported AWs in your sector_____
4. Sectoral meeting held on_____at Village _____(Meeting must be held between 26th-30th of each month)
5. Topic discussed for continuing education_____

6. Staff Position:	No. Sanctioned	No. in Position	No. Attended Meeting
i) LHV/HA(F)			
ii) ANMs/MPHWs(F)			
iii) AWWs			

7. Did MS participate in the meeting Yes/No
8. No. of AWs visited by you during the month_____
9. Remarks, if any_____

Date_____ Signature

Name of MO_____

Note:

1. Reference month 1st-last day of the month under report.
2. The report is to be submitted to the project adviser (MO I/C-PHC/CHC) on the 1st working day of the following month.
3. All the MMRs recieved from AWWs in your sector till 30th should be submitted to MO I/C PHC alongwith your report.

INTEGRATED CHILD DEVELOPMENT SERVICES

FORMAT-3(A)

(MMR Proforma for Rural & Tribal Project Adviser)

Monthly Monitoring Report of Project Adviser (MO-I/C PHC) for the month of _____19 (From 1st day to last day of the month under report).

1 Name of the State_____

2 District_____ 3 Name of the PHC/CHC_____

4 Name of the ICDS Project_____

Type of Project_____(Rural/Tribal/Urban).

5 Total Number of Sectors in the PHC_____

Sectors Reported_____

6 No. of AWs in the PHC: Sanctioned_____

Functional_____ Reported_____.

7 Population: (i) Total in PHC_____

(ii) Reported AWs (All sectors)_____

8 a Number of Sectoral Level Trg. courses organised by all MOs_____.

b No of participants (All sectors)_____

9

Staff Position	No. Sanctioned	No. in Position	No. Trained
— Medical Officers	_____	_____	_____
— LHVs/HAs (F)	_____	_____	Not Applicable
— ANMs or MPHFs (F)	_____	_____	Not Applicable
— AWWs	_____	_____	_____

10 No. of AWs where supplementary nutrition was distributed.

(a)Very Regular_____(b) Moderately Regular_____(c) Irregular_____

(21+Days) (15-21 Days) (<15 days)

11 Malnourished children as compared to last month (Please Tick):

Grade II_____Increased/Decreased

GIII & IV_____Increased/Decreased

12 Quality of supplementary nutrition food:

Good/Acceptable/Poor.

13 Immunisation performance figure (To be filled in from available information at the PHC).

Total No. Immunised BCG in the PHC.	DPT			POLIO			Mea-sles	Tetanus Toxoid (Preg. Women)	
	1st	2nd	3rd	1st	2nd	3rd		1st	2nd
In the reporting month									
Total since 1st April									

14 Incidence of other imporant events:—

Incidence as compared to last month	Increased	Decreased
(a) Diarrhoea*		
(b) Total Births		
(c) Total Deaths		
i) 0 to <1 year		
ii) 1 to <3 years		
iii) 3 to <6 years		
iv) Preg. women during delivery.		

* ORT Advised Yes/No

15 Supply Position:

Supply Position	Regularly Available	Occasionally Available	Not Available
Medical Kits			
Vit. 'A'			
Iron & Folic Acid Tablets.			

16 (a) PHC Meeting held on_____

(b) DA Present Yes/No

Date_____ Signature_____

Name_____

PHC_____

Address_____

_____

_____

NOTE:

1. Despatch the report to the Central Cell within eight days after the end of each month.

2. Copy of MMR should be sent to the State Co-ordinator and Chief District Adviser within 8 days after the end of each month.

INTEGRATED CHILD DEVELOPMENT SERVICES

FORMAT-3 (B)

(MMR Proforma for Urban Project Adviser)

Monthly Monitoring Report of Project Adviser for the month of_____19 (from 1st day to last day of the month under report).

1 Name of the State_____

2 (a) Name of the City_____(b) Urban Project_____

3 Administrative Deptt: Corporation/Municipality/State Health Deptt.

4 No. of AWs in the Project: Sanctioned_____

Functional _____Reported_____

5 Population: (i) Total in Project_____

(ii) Reported AWs_____
(All sectors)

6

Staff Position	No. Sanctioned	No. in Position	No. Trained
Medical Officers	_____	_____	_____
LHVs/HAs (F)	_____	_____	_____
ANMs or MPHW (F)	_____	_____	_____
AWWs	_____	_____	_____

7 No. of AWs where supplementary nutrition was distributed:

a) Very Regular (21+Days) _____

(b) Moderately Regular (15-21 Days) _____

(c) Irregular (<15 Days) _____

8. Malnourished children as compared to last month (Please Tick):

   Grade II_____Increased/Decreased

   Grade III/IV_____Increased/Decreased.

9. Quality of supplementary nutrition food:

   Good/Acceptable/Poor.

10. Immunisation performance figure (To be filled in from available information at the PHC).

Total No. Immunised BCG in the PHC.	DPT			POLIO			Mea-sles	Tetanus Toxoid (Preg. Women)	
	1st	2nd	3rd	1st	2nd	3rd		1st	2nd
In the reporting month Total Since Ist April.									

11. Incidence of other important events:

Incidence as compared to last month	Increased	Decreased
(a) Diarrhoea*		
(b) Total Births		
(c) Total Deaths		
i) 0 to <1 year		
ii) 1 to <3 years		
iii) 3 to <6 years		
iv) Pregnant women during delivery		

* ORT Advised Yes/No

12. Supply Position

Supply Position	Regularly Available	Occasionally Available	Not Available
Medical Kits			
Vit. 'A'			
Iron & Folic and Tablets.			

13. Sectoral Training conducted_____

DA Present : Yes/No.

Date_____

Signature_____

Name_____

PHC_____

Address_____

_____

_____

Note:

1. Despatch the reports to central cell within eight days after the end of each month.
2. Copy of MMR should be sent to the state co-ordination and Chief District Adivser within 8 days, after the end of each month.

INTEGRATED CHILD DEVELOPMENT SERVICES

FORMAT-4

District Adviser's Monthly Monitoring Report for the month of_____.

1. Name of the State_____District_____
2. Number of Sanctioned ICDS Projects in the district_____
3. Number of Operational ICDS Projects under your charge_____
4. Number of Project Advisers under your charge_____
5. Details of Monthly Monitoring Reports received from the PHC of Operational ICDS Projects under your charge.

Name of ICDS Project	Name of PHC	Date of MMR Checked and despatched	Dateof PHC Level Meeting and Continuing Education	Topics Discussed (Title only)	No. of participants MO/LHV/ CDPO/MS/ Others

6. Remarks about the following events as compared to last month:

   (a) Malnourished Children (Please Tick):

   Grade II Increased/Decreased.

   Grade III & IV Increased/Decreased.

(b) Diarrhoea Increased/Decreased.

(c) Total Births Increased/Decreased.

(d) Total Deaths

i) 0 to <1 year Increased/Decreased.

ii) 1 to <3 year Increased/Decreased.

iii) 3 to <6 years Increased/Decreased.

iv) Preg. women during delivery Increased/Decreased.

7. Remarks about the (a) Co-ordination with CDPO and (b) Food Quality at AW centre:

(a) _____

(b) Good/Acceptable/Poo

Signature_____

Name (in block letters)

_____

Full Address_____

Date_____

_____

Note:

1. The Monthly meeting in all ICDS projects under your charge should be completed within 7 days after the end of each month.
2. This MMR should be submitted to Central Cell within 11 days, after the end of each month.
3. Copy of MMR should be sent to the State Coordinator within 11 days, after the end of each month.

INTEGRATED CHILD DEVELOPMENT SERVICES

FORMAT-5

Chief District Adviser's Monthly Review Report for the month of_____19.

1. Name of the State_____District_____

   Population_____.

2. Date of District Level Meeting (including ICDS)_____

3. Number of ICDS Projects in the District:—

   (a) Sanctioned_____.

   (b) Operatioal_____.

4. Number of ICDS health functionaries in the District:—

   (a) District Advisers_____.

   (b) Project Adivsers_____.

5. Name of District Adviser	Name of Project	Name of Projects/PHCs under his charge.	No. of Project Adviser reports despatched by PAs in the district to Central Cell.
i) _____	_____	_____	_____
ii) _____	_____	_____	_____
iii) _____	_____	_____	_____
iv) _____	_____	_____	_____

6. Immunisation performance in the district (These figures are to be filled from the available information for children below 1 year under UIP at the District Headquarter).

No. immunised in the distt.	BCG	D.P.T. Doses 1st 2nd 3rd	Polio doses 1st 2nd 3rd	Measles	TT to Pregnent women 1st dose/ 2nd dose
(i) During the month (ii) Total Since 1st April					

7. Remarks about the following events as compared to last month (Please Tick):

(a) Malnourished Children:

Grade II Increased/Decreased.

Grade III & IV Increased/Decreased.

(b) Diarrhoea Increased/Decreased.

(c) Total Births Increased/Decreased.

(d) Total Deaths

i) 0 to <1 year Increased/Decreased.

ii) 1 to <3 years Increased/Decreased.

iii) 3 to <6 years Increased/Decreased.

iv) Preg. women during delivery Increased/Decreased.

8. Remarks regarding food quality at AW centres:

Good/Acceptable/Poor.

9. Number of participants in Distt. Level Meeting:

   (a) District Adviser_____(b) Project Advisers_____
   (c) CDPOs_____(d) Distt. social welfare officers_____ (e) Others_____.

10. Quarterly remuneration of the District for MMRs — Received/Not received Date_____

    Distributed/Not Distributed

    Date_____

11. No. of Lectures taken for Social Welfare functionaries during the month_____.

    Remarks if any_____

Signature_____

Name (in block letters)_____

_____

Designation_____

Date_____ Full Address_____

Note:

1. The District level review meeting of ICDS should be combined with the routine monthly meeting at the District Headquarter.
2. This monthly Review Report must be submitted to Central Cell within 21 days after the end of each month.
3. Copy of MMR should be sent to State Coordinator within 21 days after the end of each month.

INTEGRATED CHILD DEVELOPMENT SERVICES

FORMAT-6

QUARTERLY REPORT OF THE SENIOR ADVISER

1. Name of the Senior Adviser_____ State_____

2. Report for the quarter ending 31st March/30th June/30th Sept/31st Dec. 199 (Pl. tick).

3. (a) District level meetings attended (Places and dates) :

   Name of Distt. _____ Date _____

   Name of Distt. _____ Date _____

   Name of Distt. _____ Date _____

   (b) Project level meetings attended (place and date) :

   Distt. _____ Date _____

   Distt. _____ Date _____

   Distt. _____ Date _____

   (c) Field visits to PHC with ICDS projects in the quarter (Place and Date) :

   Distt. _____ Date _____

   Distt. _____ Date _____

   Distt. _____ Date _____

   (d) If you have attended any other ICDS meeting, please give date and place : _____

4. No. of lectures for Social welfare functionaries delivered during the reported Quarter_____.

5. Date when Expenditure Statement despatched_____.

6. Specific recommendations if any_____.

Date_____

Signature_____.

Name_____.

Full Address_____

_____

_____

Note:

1. At least one meeting or visit is expected each month.
2. A brief report on 3 (a), (b) and (c) above should be sent to Central Cell and State Coordintor.
3. The quarterly report should be submitted to Central Cell within 30 days, after the end of each quarter.

INTEGRATED CHILD DEVELOPMENT SERVICES

FORMAT-7

Quarterly Report of the State Coordinator

1. Name of the State Coordinator_____.
2. State/U.T._____.
3. Report for the quarter ending: 31st Mar/30th June/30th Sept/ 31st Oct. 199 (Pl. tick)
4. Project Status (At the end of the reporting quarter).

Sector	**No. Sanctioned**	**No. Functioning**	**No. alloted for monitoring**
Central	_____	_____	_____
State	_____	_____	_____
Total	_____	_____	_____

5. a) No. of functionaries in postion at the end of the quarter.
   i) Chief District Advisers (CDAs)_____.
   ii) District Advisers (DAs)_____.
   (b) MMRs receipt position (at the end of reporting quarter).

Month in the reporting Quarter	CDAs Report		DAs Report		PAs (MO I/c PHC) Report	
	Expected	Received	Expected	Received	Expected	Received
1st Month 2nd Month 3rd Month						
TOTAL						

6. Consultants performance (at the end of the reporting quarter).

No. of Consultants at the end of quarter	No. of Qtly. Repts. Recd.	Training Courses			No. of courses held	Participants		
		1 day Refesher/ Seminar	2 day Intro-ductory	3 day Regu-lar		MOs	CDPOs	Others

7. Quarterly report of Senior Adviser: Received/Not received.

8. No. of Lecture hours devoted for Social Welfare functionaries during the quarter by:—

i) State Coordinator ii) Sr. Adviser iii) ODA
iv) Consultants v) CDAs vi) DAs

9. Quarterly Expenditure Statement submitted to the Central Cell by (Please Tick).

i) State Coordinator ... Yes/No

10. Monitoring Feed-back from Central Cell, received for the month of_____in the quarter.

Comments on **Action taken by State Coordinator**

a) Shortfall in MMRs

b) Staff Position

c) Sector Level

d) Supplies

e) Vital Statistics

f) Immunisation.

11. Specific problems/points (if any) related to above may be mentioend below.

12. Paper cutting/Assembly questions if any on ICDS the quarter (Please attach copies thereof).

Signature of State Coordinator Signature of

Name

Date Date

Note: Quarterly report should be submitted to Cen within 45 days after the end of each quarte

INTEGRATED CHILD DEVEOPMENT SERVICES

CENTRAL CELL, R.K. PURAM, NEW DELHI

FORMAT-8

MONTHLY REVIEW OF PROJECT PHC-WISE PERFORMANCE

STATE_____ Month_____

DISTRICT_____

Please discuss deficiencies encircled in red with district/project advisers in the next monthly meeting.

Project	PHC	PA Report R-Received NR- Not Received	Training Position No. of untrained MOs	PHC Meeting Held/not held	No. of Sectoral Training	Severe Malnutrition Status	Immunisation coverage Good/Low	Supply Vit. A A-Adequate I-Inadequate	Position Iron & Folic Acid

CHAPTER III

EVALUATION AND RESEARCH SYSTEM

1. Almost at the very outset of ICDS in 1975, it was decided that the academic community of the medical colleges of India would constitute the 'external investigator' component for evaluation and research. In this endeavour, as many as 29 senior faculty members from 27 medical colleges, located within a reasonable distance to 33 experimental ICDS projects, unanimously resolved at a meeting held at the All India Institute of Medical Sciences (AIIMS), New Delhi in November, 1975, to act as its honorary consultants with twin role of (i) evaluation and research; and (ii) orientation and training of the functionaries.

These consultants agreed to work under the overall guidance of the Central Technical Committee (CTC) of ICDS. The group unanimously laid down following guidelines to achieve various goals of ICDS:

(a) The Evaluation and Research methodology should be updated from time to time through meetings of the consultants and the academic staff of the CTC;

(b) The Evaluation and Research should involve minimum possible resources with active participation of the postgraduate students and faculty members belonging to the respective departments of the ICDS Consultants;

(c) The collation of data and its first stage tabulation should carefully be done by the research teams of the consultants;

(d) The consistency checks and the final tabulation of data should, however, be undertaken by the Biostatistics cell of the CTC;

(e) The consultants may freely communicate the findings of their ICDS studies in appropriate journals;

(f) The national data, as a matter of policy, would invariably be published by the CTC with due acknowledgement of the consultants' work or their inclusion as co-author as the case may be ; and

(g) Evaluation and Research data generated by the consultants will be used mainly for three purposes. viz. (i) to know the coverage and impact of ICDS sercvices in health and nutrition sector; (ii) for planning the expansion of ICDS; and (iii) to disseminate globally the results of Indian experiments of ICDS.

The contribution by the consultants proved to be highly cost-effective. The number of consultants increased periodically, with the expansion of ICDS. At present ICDS has 192 consultants covering 2696 projects.

2. Evaluation and Research Approaches

Following two approaches are adopted:

- Multi-centre projects initiated by the CTC. This includes (i) Annual Surveys (ii) Collaborative Research Studies.
- Individual research projects by the Consultants

(i) Annual Surveys

Surveys on Health and Nutrition parameters are conducted annually through an external evaluation system by teams led by senior members of the departments of Community Medicine and Paediatrics of various Medical Colleges in the country. Since 1976 to 1990, annual surveys (baseline/follow up studies) have been carried out over 784 projects.

The Central Bio-Statistics Cell at R.K. Puram, New Delhi, in consultation with the CTC and other Consultants, has developed necessary details for annual surveys on Health & Nutrition. A uniform sampling procedure and survey techniques are adopted. The survey cards and dummy tabulation sets alongwith the detailed guidelines for data collection and tabulation analysis are provided by the Central Bio-statistics cell. The design and mechanism of survey including sampling methodology, formats, organisation of field work and the process of data analysis are duly modified from time to time with the expansion of the programme.

The selection of population for survey is done in two stage sampling procedure. The first stage of sampling carried out at Bio-statistics Cell, selects the ICDS projects (Block/PHC/ a group of urban slums) and the second stage of sampling carried out by the consultants identifies the anganwadis from within the sampled ICDS projects. The total population of the selected anganwadis is then subjected to the survey, by the field research teams of the consultants.

The annual surveys provide data on the coverage of the beneficiaries by the ICDS services such as supplementary nutrition, immunisation and primary health care and its impact

on the health and nutritional status of the beneficiaries. The yearwise number of projects surveyed since 1976 is given in the following table :

Table 1 : Year-wise number of projects surveyed by consultants

Year of survey	No. of projects surveyed	Year of survey	No. of projects surveyed
1976-77	27	1984-85	87
1977-78	26	1985-86	61
1978-79	16	1986-87	20
1979-80	60	1987-88	80
1980-81	56	1988-89	41
1981-82	56	1989-90	32
1982-83	65	1990-91	85
1983-84	72		
		Total	784

(ii) Collaborative Research Studies

Besides annual surveys various multi-centre collaborative research studies are also planned by the CTC to generate data related to the specific objectives of the studies. These studies are conducted by consultants and their post-graduates and are confined to predetermined specified projects. The year-wise details of these studies alongwith the number of projects covered are given below :

Table 2 : Year-wise Research Studies conducted by Consultants

Sl. No.	Name of Research Study	Year of study	No. of projects
1.	Severely Malnourished Children study	1980-81 1981-82	39
2.	Morbidity and cause specific mortality study	1984-85	9
3.	Maternal Mortality study	1985-86	5
4.	Medical students' study	1986-87	5
5.	Drought study	1987-88	12
6.	Infant Mortality study	1982-83	38
		1983-84	26
		1985-86	21
		1986-87	27
		1987-88	98
		1988-89 1989-90 1990-91	In 8 states covering 95 projects every year
7.	Psycho-social Development study	1989-90	7
8.	Adolescent study	1990-91	42

Some of the important findings observed during evaluation process conducted through annual survey are tabulated below (Table 3, 4, 5):

Table 3: Health care facilities received by lactating mothers (in percentage)

Services	Availed in newly sanctioned projects (n 1890)	Availed in Projects of over 5 years operational age (n 5111)
Ante-natal care	41.9	69.6
Maternity assistance	33.8	61.5
Post-natal care	54.9	78.0

Table 3 represents the finding of the annual survey conducted in 1988. In this study 1890 lactating mothers in newly sanctioned projects and 5111 lactating mothers in projects which had completed 5 years operational age were interviewed and the number who availed of various health care facilities were recorded. Highly significant improvement in maternal services coverage is evident in ICDS projects of more than 5 years operational age.

Similarly table 4, reveals highly significant impact of ICDS scheme on immunisation status of children (1-2 years) and pregnant women.

Table 4 : Immunisation status of children aged 12-24 months & pregnant mothers

(in percentage)

Immunisation	Newly sanctioned Projects (n children 1890, mothers 2018)	Projects more than 5 years operational age (n children 5111, mothers 5367)
BCG	22	65
DPT (3 doses)	28	63
Polio (3 doses)	27	64
(BCG+DPT+Polio)	NR	57
TT (2 doses)	40	68

The impact of ICDS scheme on nutritional status of children aged 24-72 months has also been studied from time to time in various projects. Table 5 represents the comparative status as observed in 1976 during baseline study and in 1988 as seen in projects of over 5 years operational age. A highly significant improvement in nutritional status is seen in projects of over 5 years operational age.

Table 5 : Nutritional status of children 24-72 months

(in percentage)

Nutritional States	Baseline 1976 (n 27726)	> 5 year old project 1988 (n 20180)
Normal + Grade I	50.6	73.2
Grade II	28.5	21.0
Grade III + IV	20.5	5.8

Table 5 (a) : Sex-wise nutritional status of children in > 5 year ICDS Projects (in percentage)

1988 study

Nutritional status	Male children (n 10498)	Female Children (n 9682)	Both together (Male & female) (n 20180)
Normal + Grade I	76.1	70.1	73.2
Grade II	18.9	23.4	21.1
Grade III + IV	5.0	6.5	5.7

Male children enjoy significantly better nutritional status than female children of same age group.

Table 5 (b) : Location-wise nutritional status of children in >5 years ICDS projects (in percentage)

1988 study

Nutritional status	Rural (n 10850)	Tribal (n 2981)	Urabn (n 6349)	All together (n 20180)
Normal + Grade I	76.3	74.9	67.2	73.2
Grade II	18.2	17.4	27.6	21.1
Grade III + IV	5.5	7.7	5.2	5.7

Rural ICDS projects children have better nutritional status than the urban ICDS projects children while, children with grade III + IV malnutrition are maximum in tribal ICDS projects.

II. Individual research project by the consultants

These research projects are usually taken up by the post-graduate students in the form of dissertations/theses under supervision of their post-graduate teacher and guide. Table 6 gives the number of dissertations/theses/publications/presentation since 1976 todate.

Table 6 : Dissertation/Theses/Publications/Presentation

A : By Consultants	**No.**
• Theses for M.D./Ph.D	130
• Papers published in National & International Journals	130
• Papers presented at National & International conferences	125
B : By C.T.C.	
• Papers published in National & International Journals	23
• Papers presented at National & International conferences	24

CHAPTER IV

TRAINING SYSTEM

1. The honorary consultants of ICDS are the members of faculties of the departments of Preventive & Social Medicine, Paediatrics, and allied specialities at various medical colleges all over the country. There are, at present, 157 consultants who are conducting ICDS training activities. In addition, there are 28 field consultants in Tamil Nadu and 4 field consultants in Delhi who are assisting in continuing education activities of ICDS Scheme.

II. Objectives of Training : To

- Orient medical officers regarding various components of ICDS scheme and role of various functionaries.
- Enable Medical Officers to organise the infrastructure of the block for an adequate implementation and supervision of the programme.
- Enable Medical Officers to implement an effective programme of continuing education for all the functionaries of the project.
- Enable Medical Officers to develop and participate in the inbuilt system of monitoring and evaluation of ICDS.

- Enable Medical Officers to take a timely action on individual and collective health problems of the ICDS target population.

- Enable Medical Officers to enlist community participation in the imlementation of the programme.

III. Types of Training Courses

There are 3 types of training courses that are expected to be organised by ICDS consultants:

- One day Refresher training course/one day seminar on mother and Child Development Programmes.

- 2-Day Introductory training course.

- 3-5 day Regular training course.

CTC desires that every consultant should organise (i) Four 1-day, (ii) Two 2-day and (iii) One 6 to 5 day training course every year.

The present emphasis of CTC is to increase the number of Introductory and Refresher courses as these courses are cost-effective, cause minimum disruption in the activities of Health and ICDS functionaries, and stimulate maximum participation.

Participation of Programme officers, CDPOs and Supervisors should be encouraged in each of the three type of courses.

IV. Venue of Training Courses

- One day refresher course/seminar on Mother & Child Development Programmes: These should be organised only at the District or Block level. The participants should come in the morning and return in the evening

so that accommodation arrangements for their stay are not required. Refresher courses should be organised for Medical Officers who had received training three or more years back.

- Two day Introductory training course: This course should be routinely organised at the district level. However, under very special circumstances these may be conducted at medical colleges.

The Introductory courses should be particularly organised for the functionaries where backlog of untrained MOs is high. CTC will keep the consultants informed about training status in their respective zones.

- 3 - 5 day regular training course: This should be organised at the district or at the institutions where all supportive facilities like accommodation, resource persons, etc. are available.

3 - 5 day regular training course should be organised if it is certain that more than 10 participants will attend the course.

V. Participants to be invited in Training Courses

- (a) Participants for one day refresher course : The Medical Officers and the CDPOs who have been trained at least 3 years prior to the present should be invited for the refresher course.

(b) Participants for one day seminar on Mother & Child Development Programme : This activity would be mainly aimed at information dissemination on ICDS. The participants would be the district level programme managers of health and other related departments. The opinion leaders, community leaders,

hon'ble members of Parliament/Vidhan Sabha, media personnel may also be invited to attend this seminar.

• Participants for the two day Introductory course in ICDS : This course is primarily aimed for Medical Officers and CDPOs. However, other Block level functionaries may be invited as special participants.

• Participants for 3 - 5 day regular course shall be same as for the Introductory course.

VI. Syllabus for Training Course

The programme schedule as mentioned below is flexible and consultants are free to make changes in the topics and the contents of training course, depending upon local needs.

VII. Course Contents of "5-Day" Training Course Programme

Day I

Registration

Session I (45 Mts.) Integrated Training

- Introduction of participants
- Vertical training programmes concept
- Principles of Integrated Training Course
- Advantages of Integrated Training Course
- Constraints of Integrated Training Course
- Presentation of course contents of 5 day training
- Introduction and explanation of pre-course assessment

- List of NPMCD in VII Plan.

Session II (4 Mts.) MCH Programmes

- Introduction
- Objectives
- Guiding principles
- Target population
- Components
- Implementation
- Training of functionaries
- Achievements in VII Plan

Session III ($1\frac{1}{2}$ Hrs.)

- Current nutritional profile of mothers and children
- Nutrition-infection interaction and its impact on morbidity, mortality in mother & child.
- Nutrition services through different programmes
- Role of MO and CDPO and their teams
- Project level coordination for successful implementation of nutrition programmes and linkage.

Session IV (1 hr.) Safe Drinking Water (SDW)

- Importance of safe drinking water and establishment of Technology Mission.
- Availability of SDW in our country
- Role of MO and CDPO and their teams
- Project level linkages and coordination with different workers at various levels.

Session V (1½ Hrs.) Personal Hygiene, Food Hygiene, Environmental Sanitation

- Personal Hygiene
- Food Hygiene
- Environmental Sanitation
- Role of MO and CDPO and their teams
- Linkages and coordination with different workers at various levels.

Day 2

Session VI (2½ Hrs.) Diarrhoeal Diseases Control Programme

(a) Presentation & discussion (1½ Hrs.)

- Introduction
- Definition
- Magnitude of the problem
- Objectives
- Beneficiaries/Target Groups
- Organization
- Activities
- Linkages with other programmes of mother and child development
- Monitoring
- Evaluation
- Role of CDPO and MO & their teams
- Project level coordination.

(b) Demonstration (1 hr)

- Case demonstration of dehydrated child and degree of dehydration/slides
- Preparation of ORS and other home made solutions.

Session VII (1 hr.) Acute Respiratory Infections

- Presentation and discussions should cover the items as mentioned under Diarrhoeal Diseases Control Programme
- Demonstration through X-ray plates, slides etc.

Session VIII (3 hrs.) Universal Immunisation Programme :

- Presentation and discussion ($1\frac{1}{2}$ Hrs.)
- Demonstration ($1\frac{1}{2}$ Hrs.)
  - -- Different kinds of vaccines
  - -- Cold chain & other equipments
  - -- Storage and distribution
  - -- Indenting etc. by visiting an urban health unit.

Day 3

Session IX ($3\frac{1}{2}$ Hrs.) Health and Nutrition Education (HNE) messages to the community

Health and Nutrition Education

- Introduction
- What is health and nutrition education
- Objectives of health and nutrition education
- ICDS functionaries to deliver HNE

- Venue
- Channels for communication
- Coordination Mechanism
- Important health and nutrition messages to be delivered to the community.

Session X (3 hrs.) Integrated Child Development : Should cover the items as mentioned under Diarrhoeal Diseases Control Programme.

Day 4 Field Visit (Whole day)

Briefing on the field visits and division into groups

- Departure for field visit to : PHC/Sub-Centre/Anganwadi
- Reassembly and presentation of group observations and discussion.

Day 5

Session XI (2 hrs.)

- Discussion on :
  - Integrated training
  - Prospects of Integrated Monitoring/evaluation of NPMCD
  - Intersectoral Coordination and linkages
  - Strategy for integrated training of middle supervisors and peripheral workers
- Distribution of forms for post-course assessment.

Closing session

- Concluding remarks from:
  - MO
  - CDPO
  - Course Organiser
- Distribution of Certificates
- Payment of TA/DA to the participants.

VIII. Course Contents for "Three-Day" Training Course in ICDS Scheme

Day 1

Registration

Session 1 (45 Mts.) Integrated Training

- Introduction of participants
- Vertical training programmes concept
- Principles of Integrated Training course
- Advantages of Integrated Training course
- Constraints of Integrated Training Course
- Presentation of course contents of 3 day training
- Introduction and explanation of pre-course assessment
- List of NPMCD in VII Plan.

Session II (45 Mts.) MCH Programmes

- Introduction
- Objectives

- Guiding principles
- Target population
- Components
- Implementation
- Training of functionaries
- Achievements in VII plan.

Session III (1½ Hrs.)

- Current nutritional profile of mothers and children.
- Nutrition-infection interaction and its impact on morbidity, mortality in mother & child
- Nutrition services through different programmes
- Role of MO and CDPO and their teams
- Project level coordination for successful implementation of nutrition programmes and linkages.

Session IV (1 hr.) Safe Drinking Water (SDW)

- Importance of safe drinking water and establishment of Technology Mission
- Availability of SDW in our country
- Role of MO and CDPO and their teams
- Project level linkages and coordination with different workers at various levels.

Session V (1½ Hrs.) Personal Hygiene, Food Hygiene, Environmental Sanitation

- Personal Hygiene
- Food Hygiene

- Environmental Sanitation
- Role of MO and CDPO and their teams
- Linkages and coordination with different workers at various levels.

Day 2

Session VI ($2\frac{1}{2}$ Hrs.) Diarrhoeal Diseases control Programme:

- Presentation & Discussion ($1\frac{1}{2}$ Hrs.)
  - -- Introduction
  - -- Definition
  - -- Magnitude of the problem
  - -- Objectives
  - -- Beneficiaries/Target Groups
  - -- Organisation
  - -- Activities
  - -- Linkages with other programmes of mother and child development
  - -- Monitoring
  - -- Evaluation
  - -- Role of CDPO and MO and their teams
  - -- Project level coordination
- Demonstration (1hr.)
  - -- Case demonstration of dehydrated child and degree of dehydration/slides
  - -- Preparation of ORS and other home made solutions.

Session VII (1 hr.) Acute Respiratory Infections:

- Presentation and discussions should cover the items as mentioned under Diarrhoeal Diseases Control Programme.
- Demonstration through X-ray plates, slides etc.

Session VIII (3 hrs.) Universal Immunisation Programme:

- Prevention and discussion ($1\frac{1}{2}$ Hrs.)
- Demonstration ($1\frac{1}{2}$ Hrs.)
  - -- Different kinds of vaccines
  - -- Cold chain and other equipments
  - -- Storage and distribution
  - -- Identifying etc. by visiting an urban Health Unit.

Day 3

Session IX ($3\frac{1}{2}$ Hrs.) Health and Nutrition Education (HNE) and messages to the community

Health and Nutrition Education

- Introduction
- What is health and nutrition education
- Objectives of health and nutrition education
- ICDS functionaries to deliver HNE
- Venue
- Channels for communication
- Coordination mechanism.
- Important health and nutrition messages to be delivered to the community.

Session X (3 hrs.) Integrated Child Development :

Should cover the items as mentioned under Diarrhoeal Diseases Control Programme.

Closing Session

- Concluding remarks from :
  - MO
  - CDPO
  - Course Organiser

Distribution of Certificates

- Payment of TA/DA to the participants.

IX. Course contents of 2—Day Introductory Training Course

The course contents of two day training course would essentially remain the same. However, the duration of each of the session should be reduced so that all the topics of three days course can be covered within two days.

X. Course contents of the one-day Refresher Course/seminar on Mother and Child Development programme

(a) 1-day refresher course, its contents should be :

Major achievements, important problems and measures to improve the implementation.

Introduction to ICDS Scheme : objectives, services, beneficiaries, organisation, monitoring and continuing education system, roles and responsibilities of different functionaries in ICDS scheme.

National programes for mother and child development, a brief resume of each, with salient features of mutual cooperation and support of each programme to the ICDS scheme.

Progress of ICDS at the national, state and district level. Major achievements, Important problems and measures to improve the implementation.

(b) The seminar on Mother and Child Development Programme:

It should be aimed at information dissemination on ICDS scheme to district level programme officers, opinion leaders, community leaders and hon'ble members of Vidhan Sabha and parliament and media personnel.

XI. **Facilities to the consultants for training courses :**

The following facilities are being provided to consultants undertaking training activities:

(a) A fixed contingency grant of Rs.3,000/-p.a. is given to each consultant to cover Rs.100/-p.m or Rs.1,200/-p.a. for typist/clerk and the remaining amount of Rs.1,800/- p.a. for postage, stationery, and other minor expenses.

(b) the following activity-related allowance is provided to the consultants :

(i) Rs.175/-per day allowance as course organiser for the 3-5 day regular Integrated Training Course for Mother & Child Development subject to a maximum of Rs. 700/-for each course.

(ii) Rs.150/- per day allowance for Introductory course in ICDS Scheme of 2-days with a maximum of Rs.300/- for each course.

(iii) Rs.200/-per day for one day refresher course/ seminar on Mother and Child Development.

(iv) TA/DA to Medical Officers as per state government rules would be paid to consultant from ICDS budget. The CDPOs would claim their TA/DA from their parent organisation.

(v) The consultant can hire a taxi at the rates approved by the state transport authority if government vehicle is not available to go to the district/block for the caurse.

(vi) The faculty members delivering lectures may be paid Rs.75/-, Rs.100/-, Rs.150/- per session per person depending upon his/her seniority, designation (lecturer or equivalent; reader or equivalent; assoc. Prof. Prof./Director or equivalent).

Format for submitting Training Statement

The statement of training signed by the course coordinator and Accounts officer/Accountant of the Deptt. should kindly be sent to the Central Technical Committee within 10 days of completion of Training Course on the following format:

A. Training dates: Place of training (address)

B.Accounts Statement

1. Total opening Balance (Contingency+Survey +Research+Training) Rs.
2. Grant Received for Training Rs.
3. Total (1+2) Rs.
4. Exp. incurred on training course held from..... to.....
5. Balance (item 3-4) Rs.
6. No. Trained: DAs..... MOs..... CDPOs..... Others..... Total.....

Details of Expenditure

a) Total TA/DA paid to the participants Rs.

b) Total per day allowance to course organiser i.e, consultant as prescribed Rs.

c) Total paid for guest lectures Rs.

d) Contingency Rs.

Total expenditure (a+b+c+d)

(Please Give Details in Form A)

Certified that expenditure has been incurred for the objectives for which it was sanctioned and all payments have been made as per rates approved by the CTC (TA/DA-as per State Govt. rules)

Signature of Accountant	Signature of Consultant
Name	Name
Address	Address

Please note that for 3-5 day course, the resource persons should not exceed 6, and for 2 day introductory course, and for refresher course, the number of resource persons should not be more than 3.

FORM A

Disbursement sheet for Guest Lectures Honorarium and TA/DA to participants:

Honorarium to Guest Lecturers :

S.No.	Name & Designation	Amt. Recd.	Signature on Revenue stamp
1.			
2.			
3.			
4.			

Disbursement of TA/DA to participants

S.No.	Name & Designation	Amt. of TA+DA	Signature on Revenue stamp
1.			
2.			
3.			
4.			
5.			

Format V

Format for submitting demand for release of fund for Training

The consultants are requested to submit demand for the release of funds for organising the course atleast $1\frac{1}{2}$ month in advance from the date of commencement of training in the following format. Training Grant will be released within 15 days of receipt of demand.

1. Proposed dates of training
2. Expected Number of Trainees
3. Venue of the Course Distt./Block/Medical College
4. Estimated expenditure

1.	TA/DA to participants	Rs. .....
2.	Per day allowance to course organiser i.e, Consultant	Rs. .....
3.	Per day allowance to Guest Lecturers	Rs. .....
4.	Contingency	Rs. .....
	Total	Rs. .....

Signature of Consultant

Name

Address _____

_____

_____

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